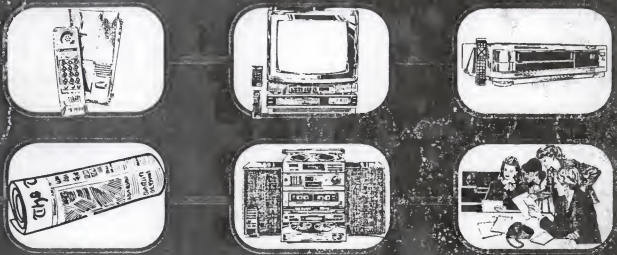
Medicare
Managed Care
National Marketing



Guide

HCFA
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Health Care Financing Administration

AUG 11 1997

Dear Colleague:

It is with pleasure that the Health Care Financing Administration presents the "Medicare Managed Care National Marketing Guide". I thank and express my sincere appreciation to our colleagues and partners in the managed care industry, beneficiary advocacy groups, health care provider industry, government regulatory agencies, and general public who helped with this project and showed such keen interest.

We received 831 comments from 77 different sources during the public comment period for the Guide. Reviewing these comments for inclusion in the Guide was labor intensive and time consuming. In addition, we invested much time and energy in collaboration with other governmental regulatory agencies whose areas of responsibility affect Medicare managed care marketing policy. These and other considerable logistical factors resulted in the release date for the Guide being later than we had hoped. As a result, however, we have a product that is sensitive to consumer and industry concerns, and reflects a more consistent view across regulatory agencies. I am grateful for your continued cooperation. I am confident that your patience will be well rewarded.

Attachment 1 includes a few explanatory remarks which will help establish a context for the purpose and scope of the Guide. Attachment 2 is a report entitled "Comment Analysis Report on the Managed Care National Marketing Guide". This report presents key statistics associated with the public comment response regarding respondent demographic and areas of concern. The report also allows those who submitted comments to understand how their comments were considered in preparation of this version of the Guide.

Among the many provisions of the Balanced Budget Act of 1997 creating the Medicare+Choice Program is one (Section 1851(h)(3) of the statute) that provides that marketing materials that are approved in one instance are deemed approved in all other instances, except for provisions that are specific to a particular area. HCFA will issue policy guidance to implement this provision in the near future.

To ensure continual accuracy, the Guide will be updated annually to reflect changes in policy or procedures. I am sure you will find this Guide to be a useful reference tool and I, once again, would like to extend my thanks to all who contributed to this document.

Bruce Merlin Fried
Director
Center for Health Plans and Providers

Attachment

- The Guide contains a Preamble Section. The preamble will be helpful because the audience that will have access to the document is far larger than HCFA initially anticipated. Originally, the Guide was designed as an operational tool to be used by the managed care plans that elect to contract with the Medicare program (the entities that submit marketing materials for review/approval) and HCFA managed care program components (those that perform regulatory review of the marketing materials). As the project proceeded over a year and a half, many other segments of the health care industry, as well as state and federal health care regulatory agencies, health care consumer advocacy groups, health care academia, and health care consultant groups showed interest in the Guide. To address the concerns of as many of these groups as possible, HCFA opened the draft Guide to public comment. The response was intense and, as expected, expressed concerns that went far beyond the intended purview of the Guide.

- There are a number of marketing areas (e.g., conduct of sales meetings, special needs of employer group marketing, etc.) that are purposely not covered in the Guide. These items were seen as beyond the scope of this Guide. In addition, the public comment process for the Guide produced many additional suggestions and comments that, while not germane to this document, are of interest to HCFA. HCFA will convene workgroups to address these marketing areas and issues in the near future.

- There are currently a number of new marketing policy and operational issues under review by HCFA. Decisions on these issues are forthcoming soon; however, not soon enough to make the release date of this Guide. In addition, HCFA is currently reviewing a number of existing marketing policies that may be changed in the near future; again, however, not soon enough to make the release date of the Guide. The term "revision forth coming" appearing after a policy scenario in this Guide indicates such an item. Until the revised policy is provided in the form of an Operational Policy Letter or a Guide addendum, the existing policy remains in effect.

- HCFA marketing policy must conform with Section 1128B(b) of the Social Security Act (better known as the "Medicare/Medicaid anti-kickback" statute). The Office of Inspector General (OIG) is actively enforcing this statute which ...."prohibits the offering or giving of any remuneration to induce the referral of a Medicare or Medicaid beneficiary, or to induce a person to purchase, order or arrange for or recommend the purchase of ordering of an item or service paid in whole or in part by the Medicare or Medicaid program". We will consult with OIG frequently on marketing issues that fall within this statute.

- HCFA is faced with a challenging issue regarding the desire to use simple, "consumer friendly" language in beneficiary notification materials and the need for uniform, technically adequate language regarding legal definitions found in statutes and regulations. Technical/legal language is often confusing and frustrating to the beneficiary. These details are often necessary to avoid misunderstandings regarding contractual

responsibilities and legal liabilities; however, such misunderstandings often lead to expensive and equally frustrating appeal actions (reconsiderations) by the beneficiary. HCFA was fortunate to have the support of the Consumer Coalition for Quality Health Care to coordinate a preliminary review of the model beneficiary notification materials in the Guide. A workgroup will be convened to further address this area. A detailed study of the best way to make beneficiary notification documents consumer friendly, to the extent practicable, will be undertaken.

- HCFA wants to foster increased emphasis on contracting health plans assigned to the Medicare population with disabilities. An ongoing workgroup will be convened to address this issue. HCFA takes seriously our responsibility to ensure that Medicare beneficiaries with disabilities have adequate access to the managed health care option.

COMMENT ANALYSIS REPORT ON THE MEDICARE MANAGED CARE NATIONAL MARKETING GUIDE

NOTE: This report is designed to give a brief accounting of the results associated with the November 1996 open comment period for the proposed Medicare Managed Care National Marketing Guide (hereafter referred to as "the Guide"). This report addresses two basic needs:

1. To inform the public of the extent of interest in the Guide; i.e., the types of respondents and the volume of comments, etc.

2. To give the public some accountability of how HCFA responded to the comments.

Item 1 is addressed by a brief breakout of respondent demographics and the nature of their concerns. Item 2 is addressed by a representative listing of the comment review panel's decisions on items selected for inclusion (Yes) or rejection (No) in the Guide. In addition, information is provided for comments selected for "future action" (Future). A HCFA response to every comment is not possible. However, scrutiny of the review panel listings will allow respondents to determine the outcome of their comment by associating them with the general comment types included in the "Yes", "No", and "Future" category listings.

An explanation of HCFA's rationale for rejection of comments is included in the "No" listing. The comment is preceded by the letter "C" and the rejection rationale with the letter "R". A rationale is not provided for comments in the "Yes" or "Future" listing. As one would expect, many comment items were repeated several times by different respondents on issues of great interest to the public. A number in parentheses; e.g., (9) indicates the number of times the comment was repeated.

COMMENT DEMOGRAPHICS:

1. A total of 77 organizations/entities submitted 851 comments (the 851 figure includes an approximate 21 percent duplication rate; i.e., 180 of the comments are duplicates).

2. The comments were triaged into six categories:

   A "Editorial" (Typographical, punctuation, grammar corrections, etc.) - 36 or 4 percent.

   B "No Change" (Comment suggested change to existing statutes and regulations that cannot be changed) - 116 or 14 percent.

   C "Simplify Language" (Make language more consumer friendly) - 50 or 6 percent

   D "Clarity" (Rewrite to clarify the issue) - 205 or 24 percent

E "Future Issue" (Item not within the purview of the initial guideline) - 60 or 7 percent.

F "Panel Review" (Item merits consideration by review panel for inclusion into the guideline) - 384 or 45 percent.

3. Breakout of panel review: Total comments reviewed = 384.

   Decision categories: (yes, no, duplicate, technical revision, future, item removed from guidelines).

   A Yes (comment will be incorporated into guidelines) - 117 or 30 percent.

   B No (comment will not be incorporated into guidelines) - 92 or 24 percent.

   C Future (comment not within purview of initial issuance of guideline; but worthy of future consideration) - 23 or 7 percent.

   D Technical revisions (requires revision of item by person with technical expertise on the Comment item) - 63 or 16 percent.

   E Item removed from the guideline (The item commented upon has been removed from the guideline) - 7 or 2 percent.

COMMENT REVIEW PANEL CATEGORY LISTING:

YES: (Comment Included in guide)

1. Same standard for mid-year notification as yearly notification (i.e., 30 days) (4).

2. Remove annual 1-X limitation of nominal value gifts; tracking problem (7).

3. Post enrollment promotional activity can be part of VAS ($10 limit) if not in ACR (3).

4. In Evidence of Coverage (EOC) distinguish between Medicare Part-B and health plan premiums (3).

5. Include in all forms, letters, EOC, etc., information about ramifications of dropping Medigap insurance after joining an HMO. Generally, strengthen information in this area (7).

6. Include accurate "coordination of benefits" information in appropriate beneficiary notification materials.

7. Include appropriate information about Physician Incentive Payments (PIP) (4).

8. Include appropriate information about Peer Review Organizations (PROs) (7).

9. Use clear, consistent, standard definitions of "emergency care", "urgently needed services", and "lock-in" throughout the guide (6).

10. Include definition and information on "follow-up care".

11. Clarify sections of guide that cover drug items; e.g., "approved drug lists" and "formularies" (4).

12. Benefits sections of guide; give complete and updated listing of services (5).

13. Remove Option-B information regarding provision of services to beneficiary prior to enrollment (7).

14. Include information on marketing and the "disabled" Medicare population.

15. Include PIP information in the annual notice so members know financial influence on doctors prior to electing to stay with the HMO (2).

16. Strengthen "grievance" language and , to the extent possible, make more user friendly (3).

17. Make "appeals" language consistent throughout document; explain the administrative appeals - administrative law hearing process; explain the expedited appeals review process (7).

18. Give better explanation of "outside USA" service policy (Canada and Mexico) (2).

19. Allow plans that have a "worldwide services benefit" to advertise it.

20. Clarify that "disruptive behavior", a reason for involuntary disenrollment, includes a final review by HCFA because such behavior may be an indication of illness, which would prohibit disenrollment by the plan (4).

21. To the extent possible, try for more "user friendly" language throughout the guide (5).

22. Reduce the size (number of questions asked) of the application form (4).

23. Cost contract language should indicate the beneficiary share of services (co-pay and deductibles, etc.). Warn the beneficiary more explicitly about the costs of seeking services "out of plan".

24. Broaden section on plan promotional activity; give more examples of policy interpretations (8).

25. The terms "Evidence of Coverage (EOC)" and "Plan Contract" can be used interchangeably.

26. Remove the model disenrollment form from the EOC and put it in the section with the other beneficiary notification materials (3).

27. Providers can announce complete plan affiliations to their patients on an annual basis.

28. Plans must provide, prior to enrollment, documents such as the handbook, EOC, etc., to prospective members if they request them.

29. Indicate that appropriate beneficiary notification materials can be used by employer groups; however, some special notifications for these groups may be required.

30. Plans may have sales packages with modified content for different geographic regions within its service area (e.g., clinic and provider listings can be limited to specific geographic areas within the entire service area).

31. Try for uniform language and format in the "Marketing Tips" section of the guide.

32. Include as many operational guides (policy interpretations) as possible regarding the "Use and File" system.

33. EOC will include information on the plan's medical referral policy.

34. Include a "warning letter" in the model beneficiary notification section regarding involuntary disenrollment for failure to pay premiums.

35. Change the term "Medicaid recipient" to "Medicaid beneficiary".

36. Indicate in the EOC that beneficiaries who go out of plan in risk contracts, and expect the plan to pay for the service, should send the plan a copy of the service claims/bills to the plan as soon as possible; this will expedite the plan's review of the claim and result in more timely payment by the plan or notification of the beneficiaries needed to file a "reconsideration" appeal (4).

37. Include "experimental services" as a non-covered Medicare service.

38. Include a general statement in appropriate beneficiary notification and promotional materials to call the health plan customer service number for full information on an item or to have questions answered (5).

39. Include information on "nursing facility coverage".

40. Include more information on the "point-of-service" option (3).

41. Explain (give beneficiary warning) about "physician panel closure" ; i.e., a specific physician may not be available to a new member because the plan's physician panel has determined that the physician has reached full service capacity.

42. Explain that not all health plans require a prior hospital stay to be eligible for home health benefits.

43. Indicate that under certain circumstances (e.g., hospital outpatient services, durable medical equipment, ambulance services, etc.) the beneficiary may be charged above the "limiting charge" if they go "out-of-plan".

44. Explain coverage priority associated with employer groups , the working aged, secondary payer, and coordination of benefits (3).

45. Remove "Recommended" from the title of the document.

46. Explain which parts of the guide are mandatory and which are voluntary (4).

47. Indicate that beneficiaries may obtain their own legal counsel for the appeals process.

48. Limit the discussion on drug benefits to basic information; e.g., indicate that the plan uses a drug formulary but do not go into a detailed explanation. Provide a plan phone number for the prospective plan member to call for full details on the plan drug benefit (4).

49. Provide model letters for the "Use and File" program (3).

50. Define and explain the difference between "enrollment form" and "enroll by mail form".

51. Acknowledge and explain that it is possible to have "appeal" and "grievance" issues filed on a single medical incidence (i.e., different complaint items associated with the same medical incidence).

52. In "Appeals/Grievance" section include information that beneficiaries may appeal "non-covered" Medicare services in plan's "basic" benefit package.

NO: (Comment not included in guide)

1. C - Annual Notice of Change: Revise policy of allowing plans to use EOC and member handbook instead of formal "Annual Notice Letter" when there has been no change to benefit package or premium rates.

   R - Under the above circumstances, there is no risk to the beneficiary if notification of the new year's contract comes via the plan's member handbook or the EOC. Both the plan and HCFA are spared the resource commitment of development and review of an unnecessary notification document.

2. C - Include in the guide HEDIS information required for the annual notice.

   R - Not necessary; HCFA Operational Policy Letter (OPL) provided the information.

3. C - The model "Annual Notification Letter" should point out what services in the plan's benefit package are standard Medicare fee-for-service (FFS) benefits and which are supplemental (i.e., paid out-of-plan savings or covered by member premiums).

   R - This information is provided in the member handbook and/or the EOC. The notification letter does require information on any new benefits approved for Medicare FFS and any new plan benefits.

4. C - Require beneficiaries to initial the yes/no checklist on the application form to insure that they understand the item and the check is not being completed by someone else.

   R - Initials do not insure the beneficiary understands the information any more than a "check" in the yes/no box. Neither is the initialing process likely to deter someone else from assisting the beneficiary in filling out the application.

5. C - Include in the EOC detailed information on how benefits are funded. Include explanation on relationship between beneficiary premiums, co-pay and deductible requirements, adjusted community rate process and plan savings, and the plans adjusted averaged per capita cost-capitated reimbursement.

   R - These items are too complex to use plan marketing/ notification materials as the vehicle to inform beneficiaries. HCFA prefers to use other educational/information vehicles for such items (e.g., HCFA beneficiary services staff, beneficiary advocacy counselors, special brochures, etc).

6. C - Place in the EOC a section on how financial liability of the member, plan, government, etc. is determined.

   R - The EOC is not the appropriate vehicle for such general information. The EOC represents the contract between the plan and the member; it should not be used to convey technical managed care information.

7. C - Use more consumer friendly language in the Medicare appeals section of the guide.

   R - HCFA agrees that the overall language of the guide should be as "consumer friendly" as possible; however, key technical terms and processes that could result in misunderstandings and legal actions between beneficiaries, health plans, and HCFA, will be expressed in current regulatory language.

8. C - Recommend change to expand time period to select a new provider beyond 30 days (i.e., the notification period from plan to beneficiary indicating the member must choose a new provider due to loss of the physician as a plan provide participant).

   R - HCFA believes 30 days is adequate time for the process. Beneficiaries should not be kept without a primary care physician to coordinate health care beyond 30 days.

9. C - Discuss "flexible charge" structures throughout the guide.

   R - Flexible charge structure is discussed in the appropriate section of the EOC. It is not required in other sections of the guide.

10. C - Include information on retroactive disenrollment in the guide.

    R - This topic is not germane to the marketing guide. This action is an operational procedure that allows HCFA to correct administrative errors and is only relevant to managed care enrollment in that context.

11. C - Correct misinformation about enrollment/disenrollment timeframes in the guide.

    R - The timeframes in the guide are correct.

12. C - Use more consumer friendly language discussing such items as appeals, emergency care, urgently needed services, lock-in, etc., (6).

    R - While trying to use consumer friendly language throughout the guide, HCFA has decided to use regulatory language for key technical terms that, if misunderstood, could precipitate legal action between beneficiaries, the health plans, and HCFA.

13. C - Expand drug formulary information in appropriate guide sections.

    R - The subject is too complex and lengthy for the guide. It is sufficient for the guide to inform beneficiaries of the issue and indicate where beneficiaries can call/write/go for full information on the topic.

14. C - Change the name of the guide, it goes far beyond the scope of marketing material review .

    R - While the guide has grown in scope from its original intended audience, it is still primarily a tool to be used by managed care health plans contracting with HCFA and the HCFA components regulating Medicare managed care marketing. The name accurately depicts the intended use of the document.

15. C - Raise the "nominal value" limit for promotional gifts beyond $10 (9).

R - Statutory/Regulatory authority does not permit an increase in the $10 limit.

16. C - Develop a system of standard disclaimers for all beneficiary notification materials.

R - HCFA is not certain standard disclaimers are appropriate at this time. Exceptions to guideline instructions/policy will be considered on a individual case basis until sufficient data are collected to justify a general disclaimer for the item.

17. C - Include in the guide a "carrier/fiscal intermediary" section which explains under what circumstances the health plans are regulated by the fiscal intermediaries and carriers.

R - Not ready for comment. An OPL is coming out on this subject in the near future.

18. C - Prohibit physician promotional activity.

R - While HCFA does not promote these actions , if the activity adheres to the guide instructions/limitations, it would be inappropriate to refuse a physician the right to communicate with his/her patients regarding the managed care health plans in which the physician participates.

19. C - Remove "point-of-service" (POS) information from the guide until HCFA has more experience and can better define the service/benefit.

R - There is adequate information available on POS to include in the guide. As experience is gained, amendments to the guide on this subject will be made.

20. C - Require health plans to send separate "annual notice" letters each year, even when there have been no premium or benefit changes from the preceding year.

R - HCFA maintains its position that this is a unnecessary expense to the health plan and that the beneficiary's rights and concerns are served by receiving a copy of the plan's handbook or Evidence of Coverage (EOC).

21. C - Allow expansion of "value added service" (VAS) beyond $10 nominal value. Remove VAS from marketing review regulation (12).

R - Such actions would violate the "anti-kickback" statutes/regulations enforced by the Office of the Inspector General.

22. C - Allow the "SSA Representative Payee" to be eligible to sign documents for a beneficiary along with a legal guardian or someone with durable power of attorney.

R - This item was researched and is not possible to adopt; it violates both federal and state statutes/regulations.

23. C - Include in the EOC more technical information on "Adjusted Community Rates" (ACR) , how premiums are derived , and what services the premium covers.

R - The subject is too technical to include in the EOC. HCFA provides separate brochures covering such technical topics; however, such items are best explained, if possible, person to person by a beneficiary advocacy group person, HCFA "Hotline" counselor, HCFA regional office staff, or other beneficiary support resource.

24. C - Expand information on HCFA prohibitions regarding providers stressing one health plan with whom they participate, over another.

R - The guide adequately covers this topic. No additional information required.

25. C - Provide more information on 30 day "prior notice" of benefit change (annual and midyear).

R - The guide adequately covers this topic. No additional information required.

26. C - Give more examples of how the $10 Nominal Value policy applies to plan marketing activities.

R - The guide contains all the examples currently available. As new situations come to HCFA's attention and policy decisions are reached, they will go into guide amendments.

27. C - Replace technical language with more consumer friendly language.

R - An effort to address this issue was made; however, on advice of HCFA counsel, it was decided that key definitions (e.g., lock-in, emergency services, urgently needed services, etc) that, if misinterpreted, could lead to appeals and other follow-up legal activity, would appear in the guide in regulatory language. There are several beneficiary informational brochures provided by HCFA that explain these items in more user friendly language.

28. C- Require plan to list NCQA accreditation, if available, in the EOC.

R- HCFA does not currently sponsor any accreditation body for its Medicare managed care contracts program. The matter is under consideration at this time. The plan may, on its own accord, indicate any accreditations or honors it possesses.

29. C - In the "Marketing Tips", "Must Use", section of the guide, require benefit limitation information be provided (e.g., co-pays, deductibles, service duration or $ limits, etc.).

R - Not all marketing vehicles are appropriate for this type information; therefore, it would be inappropriate to place a demand for this information in the "Must Use" section. The guide contains instructions for the inclusion of this information in all appropriate places.

30. C - Include in the EOC and other beneficiary notification materials a statement that indicates that only the HMO can determine what services are medically necessary.

R - Such a statement would violate existing Medicare regulations by eliminating the beneficiary right to the appeal process.

31. C - Anytime there is a change in benefits (e.g., midyear), a new EOC should go out to the beneficiary member.

R - An amendment page to the existing EOC will suffice to inform the beneficiary. The printing and distribution of a new EOC would be an unnecessary burden on the contracting plan.

32. C - Change the requirement on beneficiary benefit change notification from "prior to or concurrent with....." to only " prior to".

R - This suggested change would rule out the positive gain to the beneficiary when a plan offers an increase to the benefit package by making the beneficiary wait 30 days before qualifying for the new benefit. Plans are aware that any decrease in the benefit package requires advance notice to the beneficiary.

33. C - In the EOC welcome letter, put in a summary of how the beneficiary may be effected if they give up their Medigap insurance.

R - This issue is covered adequately in the EOC and other places, it does not need to appear in the welcome letter.

34. C - Provide an expanded section in all marketing materials regarding the "appeals process".

R - Technical information such as the "appeals process" is not appropriate for ALL marketing materials. The EOC, Member Handbook, and other such documents are the appropriate place for such information.

35. C - Rewrite the disenrollment section.

R - More specific information must be given on what should be rewritten. HCFA staff believe the guide contains adequate disenrollment information for the purpose of the guide.

36. C - Providers should be able to notify members of termination of contract with the health plan.

R - All contractual associations with Medicare managed care HMOs/CMPs are between HCFA and the health plan; HCFA does not negotiate or regulate the provider networks of contracting health plans.

Therefore, it would be inappropriate for HCFA to approve provider notification of contract termination.

37. C - Allow disenrollment over the phone for "disabled" beneficiaries.

R - Currently, HCFA is undecided if this would be an advantage or disadvantage for Medicare disabled beneficiaries. What seems to be an advantage regarding ease of process could become a disadvantage if abused by unscrupulous persons having influence with the beneficiary. (The matter is under consideration)

38. C - Change HCFA policy to have 5-day response time line for appeals processing and response back to the beneficiary.

R - The subject of "expedited" appeals review is under consideration by HCFA. At this time, the 5 day request is not feasible. An "Operational Policy Letter" on this subject will appear when a decision is reached on the matter.

39. C - Give detailed explanation in marketing materials regarding physicians not being able to practice medicine as they would prefer because of restrictions by the HMO.

R - The marketing guide contains ample information regarding possible limitations to specific physician and hospital access, along with drug formularies, etc. In all cases the beneficiary is instructed to call the health plan for full information on these matters. Physicians that cannot reconcile their professional standards with the treatment/utilization policies of the health plan SHOULD NOT be a part of the plan's provider network. HCFA DOES NOT promote or permit substandard treatment of Medicare or Medicaid beneficiaries under any health care delivery system.

40. C - Make the Annual Notification Letter part of the "Use and File" review system.

R - No, this document is the annual instrument establishing contact between the beneficiary and the health plan. HCFA will always be interested in the content of this document.

41. C - Change the policy regarding sending a disenrollment form with a new member information package.

R - No, it is appropriate for members to understand the ease of disenrolling from a Medicare managed care plan; the disenrollment form is part of that "security" that HCFA feels is appropriate for the beneficiary.

42. C - Change information on "referral" from the primary care physician to specialists criteria. Some plans allow direct access to a specialist if they are in-house, plan specialists.

R - This criteria pertains to referral to contract specialists outside the plan's standard non-specialist provider network. This information is provided to avoid charges of beneficiaries going out of plan or seeking services without referral.

43. C - Change policy to allow plans to reward members who maintain membership for an extended period (e.g., years, 5 years, etc.).

R - This is not allowable because it violates the basic principal that all Medicare beneficiaries must have access to the same benefits from the health plan.

44. C - HCFA should not defer to State law on the alternative beneficiary signature issue.

R - The "first meet all state and local requirements" is a policy that HCFA has pursued throughout the course of the Medicare and Medicaid programs. Inter-governmental cooperation is absolutely necessary in the administration of the entitlement programs.

45. C - Remove the requirement for "disclaimers" on drug marketing materials (e.g., the statement on plans having drug formularies).

R - It is imperative that beneficiaries considering joining a Medicare managed care health plan, understand the limitations of benefits associated with the plan. Therefore, while the marketing materials are not required, under all circumstances, to discuss the limitations in detail, they must inform the beneficiary they exist and where the beneficiary can call for full information of the subject. This primary beneficiary right WILL NOT CHANGE.

46. C - Change the Provider Termination Letter to remove the question regarding the question on the physicians willingness to retain the beneficiary in case of contract termination.

R - No, this is a legitimate question and is of service to the beneficiary.

47. C - Integrated provider systems that choose to contract with HCFA under the new PSO/PSN legislation request HCFA allow the use of the statement "a provider sponsored network with a Medicare contract" to meet the HCFA approved HMO marketing statement "A federally qualified HMO with a Medicare contract".

R - The PSO/PSN legislation has not been passed nor regulations developed for the program. While such a request seems reasonable, it is too early to for decisions on such issues.

FUTURE: (Comments not within the preview of the current guide; but, which are of interest and will generate future HCFA operations/policy workgroups)

1. Consider standardization of all beneficiary notification materials and forms; make the use of these forms mandatory.

2. Include in the EOC extensive information on all benefit packages offered by the plan (e.g., basic, flexible, supplemental, high/low option, etc.).

3. Consider marketing regulations that will ensure an appropriate emphasis for the "disabled" Medicare population.

4. Consider marketing regulations to ensure an even distribution of member health status for the health plans (how to address the positive bias selection issue for Medicare managed care contractors).

5. Determine the marketing emphasis plans should/must give to "end-of-life" benefits.

6. Reconsider HCFA marketing policy regarding multiple market areas for a single contract (e.g., multiple EOCs, flexible charge structures, marketing strategies).

7. Possible expanded promotional activities (e.g., "value added services") if they relate to the adjusted community rate (ACR) process.

8. Expand the operational policy scenarios that relate to the "Use and File" program.

9. Expand the "plan promotion" section to include as many operational scenarios as possible.

10. Define the relationship between HCFA's central and regional offices regarding marketing regulatory responsibilities.

11. Model beneficiary notification letters for scenario where the physician leaves the health plan and the beneficiary must change physicians.

12. Define the relationship between HCFA's Marketing guide, Operational Policy Letters, and the managed care HMO/CMP manual.

13. Determine the appropriate vehicle to effectively notify prospective managed care beneficiaries of plan benefit limitations and "gag clause" type policies.

14. Consider future policy on "unsubstantiated marketing claims"; especially comparison claims (e.g., "this product/item is better than that product/item").

15. Consumer friendly language v.s. the need for technically correct language in marketing materials.

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CHAPTER I

PREAMBLE

PREAMBLE

The goal of this Guide is to provide managed care plans and the Health Care Financing Administration (HCFA) marketing review authorities with a tool that will: (1) expedite the review process, (2) conserve resources by avoiding multiple submissions/reviews of a document prior to final approval, (3) ensure uniform marketing review across the nation, and most importantly (4) provide Medicare beneficiaries with current, accurate, consumer friendly, managed care marketing information that will assist them in making informed health care choices.

This preamble is presented to express some of the basic operational assumptions associated with Medicare managed care contracting, note the limitations of the Guide and, indicate the process HCFA will use to incorporate new items into the Guide on an ongoing basis.

Background

Marketing review consists of: (1) pre-approval of marketing materials before they are used by the managed care health plan, (2) review of on site marketing facilities, products, and activities during regularly scheduled contract compliance monitoring visits, (3) random review of actual marketing pieces as they are used in/by the media, and (4) "for cause" review of materials and activities when complaints are made by any source. **The Guide was designed primarily to assist with pre-approval of marketing materials and secondarily as a policy reference source for marketing activities (e.g., health fairs, health promotional events, and educational events).**

HCFA considers marketing materials to include any material used by the health plan to contact the beneficiary. As such, marketing materials go beyond the public's general conception of advertising materials and include all notification forms and letters used to enroll, disenroll, and communicate with the member on many different membership scenarios. **Model forms, letters, and instructions constitute a majority part of the Guide.**

HCFA policy regarding the mandatory aspects of marketing materials (particularly with the beneficiary notification materials) has always been to indicate the minimal information that must be included in the material. The format and additional information for the letter/form has been left to the discretion of the health plan. It is HCFA's policy to interfere as little as possible with the way a contracting plan conducts business, as long as the message to the beneficiary is truthful and as clear/consumer friendly as possible. **The mandatory use of standardized forms and notification letters is under consideration by HCFA. For now, the policy remains as stated above. Use of the model notification materials in the Guide is on a voluntary basis; however, to the health plan's advantage, use of the model notification materials does not require prior review of these documents by HCFA.**

Information Items

1. The Guide will be an ongoing document which will be updated on a regularly scheduled basis (quarterly or semi-annually). A HCFA panel will determine which items will be included in the updates (e.g., all HCFA Operational Policy Letters (OPL) affecting marketing matters which were issued during the interim time period between Guide amendment issuances).

2. Voluntary and mandatory content of the Guide: The Guide contains both voluntary and mandatory information for contracting health plans. At this time, use of the model beneficiary notification letters, enrollment/disenrollment forms, and the Evidence of Coverage (EOC) is voluntary. Use of these model documents, however, does not require prior review and approval by HCFA. The HCFA policy statements, often contained in marketing scenarios, represent official HCFA policy and must be followed by contracting health plans.

3. The primary HCFA/health plan contractual frame of reference in the Guide is risk contracting. The model beneficiary notification documents and many of the operational policy scenarios are focused on risk contracting. Where applicable, alternative language is provided for cost contracting and speciality scenarios such as the new point-of-service (POS) and Visitors Program features which may be applicable for risk and/or cost contractors.

4. Many of the Guide's model notification documents are accompanied by a checklist for the document. These checklists are provided as an operational tool to assist the health plan and HCFA with preparation and review of the document. All checklist items must be addressed in the document. If a checklist item did not appear previously in the document, then it represents a new data collection item required by HCFA. **NOTE TO PLAN**: This item is limited by the voluntary/mandatory statement in item # 2 above.

5. The Guide represents HCFA's current, official position on marketing policy and operational instructions (including new requirements not previously expressed by HCFA). The content of the Guide is to be followed by both contracting health plans and HCFA managed care components. **NOTE TO PLAN:** This item is limited by the voluntary/mandatory statement in item # 2, above.

6. The introduction sections of each chapter or main sub-division of a chapter contain valuable information regarding important operational and/or policy content for the section. Particular attention should be given to the content of these introductory pages.

NOTE TO PLAN: This Guide is provided as a convenient tool to supplement, not replace, the marketing chapter of the Medicare Health Maintenance Organization/Competitive Medical Plan (HMO/CMP) Manual and marketing review policy updates provided in OPLs. Compliance with HCFA marketing policy and operational instructions found outside the National Marketing Guide remains a requirement for participation in the Medicare managed care program.

CHAPTER II

PROMOTIONAL ACTIVITIES

INTRODUCTION

This chapter reviews the use of promotional activities relating to the enrollment and retention of members. Many plans offer gifts to potential enrollees if they attend a marketing presentation. Section 2211of the HMO/CMP Manual marketing chapter permits this practice as long as such gifts are of nominal value and are provided whether or not the individual enrolls in the plan. . Nominal value is defined as an item worth $10 or less, based upon the retail purchase price of the item. Cash gifts are prohibited including charitable contributions made on behalf of people attending a marketing presentation. **NOTE TO PLAN:** This definition supersedes that found at section 2211.C in the HMO/CMP Manual. The dollar amount associated with the definition will be periodically reassessed by HCFA.

Definition and policy changes in this chapter are a result of compliance with directives from the Office of Inspector General regarding monitoring of Medicare managed care operations under several statutes which prohibit unlawful influence/inducement of Medicare beneficiaries.

Promotional activities must conform to the requirements of Sections 1128A(a)(5) and 1128B(b) of the Social Security Act. Section 1128A(a)(5) of the Act provides for a civil monetary penalty against a person or entity that offers or transfers remuneration to a Medicare or Medicaid eligible individual that the person or entity knows or should know is likely to influence such eligible individual to receive or order services from a particular provider (including an HMO). Section 1128B(b) of the Act, the Medicare and Medicaid anti-kickback statute, prohibits the offering or giving of remuneration to induce the referral of a Medicare or Medicaid beneficiary, or to induce a person to purchase, or arrange for, or recommend the purchase or ordering of an item or service paid in whole or in part by the Medicare or Medicaid programs.

On the following pages, health plans will find responses to a number of frequently-asked questions and a definition of the term value-added services.

FREQUENTLY ASKED QUESTIONS AND ANSWERS REGARDING PROMOTIONAL ACTIVITIES TO ENCOURAGE AND RETAIN ENROLLMENT

Question 1
We purchased books on health maintenance that we plan to give away to anyone attending one of our marketing presentations, regardless of whether or not they enroll in our plan. Because we purchased a large number of these books, we were able to buy them at a cost of $9.99 per book. However, on the inside jacket, the retail price is shown as $19.99. May we give these books away at our marketing presentation?

Answer 1
No. The retail purchase price of the book is $19.99, which exceeds HCFA's definition of nominal value.

Question 2
We are participating in a health fair during which we will have marketing staff present. During the fair, we will offer a number of free health screening tests to people who attend. The value of these tests, if purchased, would be considerably more than $10. Is this permissible?

Answer 2
No. You may not offer these free tests because their value exceeds HCFA's definition of nominal value.

Question 3
At our plan, we offer gifts of nominal value to people who call for more information. We then offer additional gifts if they come to marketing events. Each of the gifts meets HCFA's definition of nominal value, but taken together, the gifts are more than nominal value. Is this permissible?

Answer 3
Yes.

Question 4
Listed below are some possible promotional items to encourage people to attend marketing presentations:

- Meals
- Day trips
- Magazine subscriptions
- Event tickets
- Coupon book (total value of contents)

Are these types of promotions permissible?

Answer 4

Yes. All these promotional items are permissible as long as they are offered to everyone who attends the event regardless of whether or not they enroll and as long as the gifts are $10 or less.

Question 5

Can a health plan advertise eligibility for a raffle or door prize of more than nominal value for those who attend a marketing presentation if the total value of the item is less than $10 per person attending?

Answer 5

No. You cannot have a door prize of more than nominal value. Such gifts or prizes are prohibited by HCFA.

Question 6

What about post-enrollment promotional activities? Are there any rules prohibiting such items or activities as coupon books, discounts, event tickets, day trips, or free meals to retain enrollees?

Answer 6

Currently, the HMO/CMP Manual states that plans may not offer post-enrollment promotional items such as rebates, dividends, or other promotional items that in any way compensate beneficiaries for lower utilization of services. Any promotional activities or items offered by plans, including those that will be used to encourage retention of members, must be of nominal value and must be offered to all eligible members without discrimination. The same rules that apply to pre-enrollment promotional activities apply to post-enrollment promotional activities.

Question 7

Can health plans provide incentives to current members to receive preventive care and comply with disease management protocols?

Answer 7

Yes, as long as the incentives are: (1) offered to current members only, (2) not used in advertising, marketing, or promotion of the health plan, and (3) provided to promote the delivery of preventive care.

Question 8

Can a health plan offer reductions in premiums or enhanced benefits based on the length of a Medicare beneficiary's membership in the plan?

Answer 8

No. Longevity of enrollment is not a basis for reductions in premium or enhanced benefits.[1]

Question 9

Can a health plan provide discounts to beneficiaries who prepay premiums for periods in excess of 1 month?

Answer 9

Yes. Health plans can provide discounts to Medicare beneficiaries who prepay premiums in excess of 1 month.[2] The discount must be of nominal value.

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1 This "no " statement also applies to "zero" premium plans that might want to award a nominal value gift as a reward for longevity of enrollment.

2 This item has no applicability to "zero" premium plans since prepayment of premiums is not an issue.

ADDITIONAL PROMOTIONAL ACTIVITIES

A. Referral Programs

The following general guidelines apply to referral programs under which plans solicit leads from members for new enrollees. These include gifts that would be used to thank members for devoting time to encouraging enrollment. Gifts for referrals must be available to all members and cannot be conditioned on actual enrollment.

- Health plans may not use cash promotions as part of a referral program.
- Health plans may offer thank you gifts of less than $10 nominal value (e.g., thank you note, calendar, pen, key chain) when an enrollee responds to a health plan solicitation for referrals. These thank you gifts are limited to one gift per member, per year.
- A letter sent from the health plan to members soliciting leads cannot announce that a gift will be offered for a referral.

B. Health Fairs and Health Promotion Events

Many health plans are interested in offering health fairs or social events that promote health awareness and a sense of belonging among seniors. Plans may participate in such events as either the sole sponsor of the event or as a member of a multiple-sponsor event. Application of the following HCFA policies to the condition of sponsorship is indicated by (Sole-Sponsor) for sole sponsor events, (Multiple-Sponsor) for multiple-sponsor events, and (Both) where the policy applies to both single and multiple sponsor events. **NOTE TO PLAN**: If an audience is comprised of the general public as well as Medicare beneficiaries, the following policies apply to the entire audience:

- Such events should be social and should not include a sales presentation. (Both)
- Advertisements for the event can be distributed to both members and non-members. (Both)
- The value of any give away or free items (e.g., food, entertainment, speaker) cannot exceed $10 per attending person. For planning purposes, event budgets can be based on projected attendance. The cost of overhead for the event (e.g., room rental) is not included in the $10 limit. (Both)
- Pre-enrollment advertising materials can be made available as long as enrollments are not accepted at the event. (Both)

- No sales presentation can be made at the event. Response by a plan representative to questions will not be considered a sales presentation if no enrollment form (other than an EBMF) is available and if no enrollment is accepted. (Both)

- If offered, door prizes/raffles cannot exceed the $10 limit. (Sole-Sponsor) However, door prizes/raffles can exceed the $10 limit if a health plan contributes to a pool of cash for prizes or contributes to a pool of prizes such that the prize(s) is not individually identified with the plan, but is identified with a list of contributors. **NOTE TO PLAN:** A jointly-sponsored event may consist of the health plan and one or more sponsor participants who are not contracting providers with the health plan. Or, a health plan may contribute cash for prize to a foundation or another entity sponsoring the event. For example: A radio station, along with many sponsors, puts together a seniors fair. Anyone who attends may register for the door prize: a get-away weekend. The health plan may participate in the fair, contribute to the door prize, and permit attendees to register for the prize at its booth (as well as other sponsor booths). However, the health plan cannot claim to be the sole donor of the prize. It must be clear that the prize is attached to the seniors fair. No sales presentation may be made at the event. (Multiple-Sponsor)

C. Value-Added Services and Products

Value Added Services are products or services made available to the general health plan membership. Value added services are generally offered free or at a discount and include both health care and non-health care products and services. They are not in the Medicare contract benefit package or priced through the ACR process. These products and services cannot be advertised or offered to prospective health plan members. Further guidance will be provided in a forthcoming Operational Policy Letter.

CHAPTER III

SALES PACKAGES AND ADVERTISING

Introduction

The purpose of this chapter is to provide guidance to plans regarding sales packages and language that may be used in marketing materials. This chapter offers a general guide and a matrix describing marketing language that plans "Must Use/Can Use/Can't Use."

These guidelines were created by identifying language frequently omitted by plans or revised by HCFA. Acceptable language was created to meet both HCFA requirements and the needs of the health plan. Although use of suggested language is not required, we strongly recommend its use as a means of expediting the review process and of achieving greater consistency among marketing materials. At this time, it is not necessary to alter previously approved materials unless they are being resubmitted for approval of revisions.

It should be evident that some phrases may or may not apply to your health plan's benefit package or marketing strategy. We caution you to apply the information contained in this document with the understanding that it must be evaluated for applicability to your plan.

Listed below are certain informational items and phrases which are frequently omitted, yet should be present in marketing materials in order for approval to be granted.

- For risk contractors, the concept of "lock-in" must be clearly explained in all materials. For marketing pieces which tend to be of short duration we suggest: "You must receive all routine care from plan providers" or "You must use plan providers." However, in all written materials used to make a sale, a more expanded version is suggested: "If you obtain routine care from out-of-plan providers neither Medicare nor the health plan will be responsible for the costs." Modify materials if the health plan has POS or Visitors Program benefit, or is a cost contractor.

- All marketing materials must include the following statement to identify the plan as "A Federally Qualified HMO with a Medicare contract." CMPs may use "An HMO with a Medicare Contract" and/or "A MCO with a Medicare contract" rather than the term "Competitive Medical Plan" if they are state licensed as HMOs.

- Beneficiaries with disabilities must be considered part of the audience that any marketing strategy is intended to reach. Specifically for those health plans using the term "Senior" in their product name, reference must be made to the availability of the Medicare product to beneficiaries with disabilities. (See items 1 and 2 under Eligibility Clarification.)

- Readability of written materials is crucial to informed choice for Medicare beneficiaries. All member materials that convey the rights and responsibilities of the managed care organization and the member must be printed with a 12-point font size or larger. These materials include the EOC or member contract, the enrollment and disenrollment applications, letters confirming enrollment and disenrollment, notices of non-coverage

(NONC) and notices informing members of their right to an appeals process, etc. The 12-point font size or larger rule also applies to any footnotes or subscript annotations in notices. In all non-notice material (e.g., tv advertisements) the footnote must be the same size font as the commercial message.

- Definition of Outdoor Advertising (ODA)-- ODA is used to capture the quick attention of a mobile audience passing the outdoor display (e.g., billboards, signs attached to transportation vehicles, etc.). ODA is designed to catch the attention of a person and influence them to call for detailed information on the product being advertised. Due to the nature of ODA, HCFA is willing to waive the disclaimer information required with other forms of marketing media (e.g., lock-in and premium information). **NOTE TO PLAN**: The "Sales Packages and Advertising; Must Use/Can Use/Can't Use" chart provides specific application requirements for ODA.

- Be aware that in all marketing materials (e.g., brochure narratives, introductions to side-by-side comparisons, etc) the health plan must indicate it meets Medicare regulatory requirements for providing enrollment opportunity and benefit packages for both Part A&B and Part B only eligible beneficiaries. The benefit package for Part B only beneficiaries may consist of only Medicare fee-for-service (FFS) Part B services or it may consist of any additional supplementary benefits beyond the FFS Part B package up to, and beyond, Part A&B services.

- Be aware that multiple charge structures associated with flexible benefits and high/low option benefit packages (e.g., service are sub-components where the premiums are the same but co-pays and/or deductibles differ; or, different benefit packages are available to the member) must be identified in the health plan's marketing materials.

- Be aware that cost plans must market a low option or basic benefit package that is identical to the Medicare FFS benefit package (except for any additional benefits the plan may offer at no charge, for which the plan claims no reimbursement). Information on the availability of this package must appear in all of the health plan's marketing materials. The plan may, of course, offer additional optional enriched benefit packages for an additional charge to the extent they wish.

Medicare HMO Sales Package Minimum Information Requirements

This section contains guidance regarding rules that health plans are required to provide in writing to beneficiaries prior to enrollment.

1. Eligibility Requirements

A. An HMO cannot health screen its membership. However, Federal law will not allow the HMO to enroll people with End Stage Renal Disease (ESRD) (kidney failure) who are receiving routine kidney dialysis or individuals that have had a kidney transplant within the past 36 months. Currently-enrolled individuals who become Medicare eligible due to ESRD or who undergo a transplant can retain their membership. Also, individuals who have elected the Medicare hospice benefit may not enroll in HMOs.

B. Members must have Medicare Part B or Medicare Parts A and B to enroll in the HMO. For prospective members who do not have Medicare Part A coverage, the HMO may offer to sell insurance coverage that provides the same benefits as Medicare Part A or may require it as a mandatory benefit. In all cases, members must continue to pay the Medicare Part B premium once enrolled in the plan. (The health plan can choose to cover Part B benefits only and modify this language to reflect that offering.)

C. HMOs must be available to all Medicare eligible applicants who live in the service area of the HMO. The HMO must designate the service area in the sales material in terms of counties or zip codes. If a prospective member does not live in the service area, the HMO need not accept the member's application (unless they are currently a non-Medicare member of the health plan and are aging into the Medicare product line. **NOTE TO PLAN**: It is permissible for health plans to have separate marketing brochures for each geographic region in the service area so that all zip codes for the entire service area do not have to appear in all marketing brochures. This waiver DOES NOT relieve the plan from uniform benefit and marketing requirements throughout the service area (with the exception of flexible benefits specific to individual counties, e.g., Medicare supplemental policy owners.)

2. Enrollment

A. When completing an application, a beneficiary must:

1. Select a primary care physician (optional).
2. Sign and date the application.
3. Put his/her Medicare number on the application as it appears on his/her red, white, and blue Medicare card.

B. State that the application process may take 6 weeks, but that the HMO will notify the member when their enrollment is effective.

C. State that once a person enrolls with the HMO, he will receive an HMO card. This card must be used when receiving all health care services.

D. State that the HMO cannot enroll anyone in the plan who has ESRD and is receiving kidney dialysis routinely or, who received a kidney transplant in the last 36 months unless they previously were a non-Medicare member of the HMO. State that the HMO cannot enroll beneficiaries who have elected the Medicare hospice benefit.

E. State that Medigap insurance or other supplemental insurance is no longer necessary, because the HMO pays for deductibles and coinsurance usually covered by Medigap. However, if the member has a Medigap policy and decides to enroll in a plan, they may either keep the policy or, they may cancel it if they decide they like the health plan. The member will generally not need a Medigap policy if they enroll in a Medicare-contracting plan.

State that a Medigap policy could be of value to the member if they leave a plan and returned to FFS Medicare. If the member previously had a Medigap policy but dropped it while in the plan or never had one before they joined the plan, they might not be able to buy the policy of their choice, especially if they have a health problem.

Before the member gives up their Medigap policy, or allows a Medigap open enrollment period expire, the member should consider discussing their particular circumstances with their state insurance counseling office. The services are free.

The counseling offices also have free copies of *"The Guide to Health Insurance for People with Medicare."*

3. Disenrollment

A. A disenrollment request must be made in writing to the health plan, the Social Security Administration, Railroad Retirement Board, or by joining another health plan.

B. Disenrollment will be effective on the first day of the month following the health plan's receipt of the written request for disenrollment, unless the beneficiary has requested a later date.

C. Members can be involuntarily disenrolled for:
   1. Failure to pay plan premium for the basic package
   2. Permanent move outside the geographic service area of the HMO
   3. Fraud
   4. Abusive behavior

4. Lock-in Requirements/Selecting a Primary Care Physician -- How to Access Care in an HMO)

Health plans must describe rules for receipt of primary care, specialty care, hospital care, and other medical services. These rules may vary by health plan. Plans must disclose specific rules for referrals for follow-up specialty care. Prior to enrollment, prospective members must be able to obtain information regarding the health plan network coverage and rules in sufficient detail to make an informed choice.

A. When a beneficiary enrolls in a Medicare risk HMO, he/she agrees to use the network of physicians and hospitals that are affiliated with the HMO for all medical services, except emergencies or out-of-area urgently needed care.

B. For contractors with POS benefit feature or Visitors Program: List plan-specific requirements and level of coverage found in your EOC.

C. For "Cost" Contractors: After your enrollment is effective, in order for (Health Plan Name) to fully pay for medical services for you, these services (except for emergency and out-of-area urgently-needed services) must be provided or arranged by (Health Plan Name). You may receive services that are not provided or arranged by (Health Plan Name), but you will be responsible for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare Program. You may be liable for any charges not covered by the Medicare Program. **NOTE TO PLAN:** Be sure to offer adequate explanation of Medicare card use with out-of- plan utilization which is not an emergency or an urgently-needed service.

D. An HMO member selects a primary care physician (PCP) to coordinate all of the member's care. A primary care physician is usually a family practitioner, general practitioner, or internist. The primary care physician knows the HMO's network and can guide the member to HMO specialists when needed. The member always has the option to change to a different primary care physician. Changes in PCP will be effective according to the HMO guidelines which, in some instances, could be the first or the 15th day of the following month as opposed to immediately.

E. Neither the HMO nor Medicare will pay for medical services that the member receives outside of the network unless it was authorized or an emergency or out-of-area urgently-needed care except as noted above in item B. The member may be responsible for paying 100 percent of the bill.

5. Emergency Care

A. Members are not required to go to health plan-affiliated hospitals and practitioners when they experience an emergency. Emergency care means covered inpatient or outpatient services that are furnished by an appropriate source other than the health plan and that meet the following conditions:

(1) Services are needed immediately because of an injury or sudden illness.
(2) Services are such that the time required to reach health plan providers or suppliers (or alternatives authorized by the health plan) would mean risk of permanent damage to the enrollee's health.

Once initiated, the services continue to be considered emergency services as long as transfer of the enrollee to the health plan source of health care or authorized alternative is precluded because of risk to the enrollee's health or because transfer would be unreasonable given the distance and the nature of the medical condition.

B. Describe precisely where emergency coverage will be available under the plan (e.g., the United States and its Territories, world-wide, etc.).

6. Urgent Care

A. Urgent care is out-of-area care required to prevent a serious deterioration of an enrollee's health resulting from an unforeseen illness or an injury which cannot be delayed until the enrollee returns to their HMO's service area.

B. Urgently-needed care provided by non-plan providers is covered only when a member is temporarily out of the service area. If a member needs urgent care and is in the HMO's service area, the member must obtain care from the HMO's providers.

7. Appeal Rights

A. Members have a right to appeal any decision the HMO makes regarding denial, termination, or reduction of services or payment for services contained in the basic benefit package or cost plan low option. This includes denial of service after the service has been rendered (post-service) or denial of service prior to the service being rendered (pre-service).

8. Benefits and Plan Premium Information

A. Premium information must include the statement: "You must continue to pay your Medicare Part B premium."

B. When specifying benefits, annual limits (e.g., $1000 annual maximum for prescription drugs), annual benefit payout (e.g., $70 for eyeglasses every 2 years) and applicable copayments (e.g., $5 copayment for a doctor visit) must be specified. Major exclusions and limitations must be stated clearly. For example, restriction of pharmacy benefits to a specific formulary or a restricted set of pharmacies must be explained. Plans must state clearly all monetary limits, as well as any restrictive policies which might impact a beneficiary's access to drugs or services. Include a closing statement such as: "For full information on (Health Plan Name) (e.g., drugs, routine physical exam, eyeglasses, dental, etc.) benefits, call our Customer Service Department at (Health Plan Phone Number)."

C. Cost contractors must describe required low-option plans as required by regulations.

D. A statement must be made indicating that (Health Plan Name)'s benefit package is subject to change annually at the plan's contract renewal time with the Medicare Program (usually January 1).

E. Premium information must identify what portion is attributable to services not covered by Medicare.

MARKETING LANGUAGE:
"MUST USE/CAN'T USE/CAN USE" CHART

The following items: Lock-in, Eligibility, and Contract with Government, are required items in advertising and marketing materials.

Subject	Must Use	Can't Use	Can Use	Reason
Lock-in	• Enrolled members "must use (name of plan) (contracting, affiliated, or name of plan participating) providers" • "Plan available to all Medicare beneficiaries" MEDIA: All except outdoor advertising. *Outdoor advertising has the option of excluding this topic. * See definition of outdoor advertising on page 124.	• "Participating providers" unless you use plan name	• Enrolled members "must use (name of plan) (contracting, affiliated, or name of plan participating) providers"	HCFA requires lock-in for all media to inform beneficiaries of managed care requirement. Because of the length of the messages and the nature of outdoor advertising, this topic does not apply to outdoor advertising.
Quality*		• Superlatives (e.g. highest, best) • Unsubstantiated comparisons	• Qualified superlatives (e.g. among the best, some of the highest) or superlatives (e.g. ranked number 1), if they can be substantiated (Source must be identified in the advertising piece.) • "Plan delivers (adjective) quality of care." • Descriptions of plan's initiatives related to quality. • Can use satisfaction survey results. (Must disclose year and source.) MEDIA: All	Quality is not a required topic in marketing materials.

* HCFA has the discretion to disapprove language based on site visit reviews identifying substantial deficiencies in plan operation.

MARKETING LANGUAGE:
"MUST USE/CAN'T USE/CAN USE" CHART

Subject	Must Use	Can't Use	Can Use	Reason
Premiums/Costs	• If a plan premium is mentioned, it must be accompanied by a statement that beneficiaries must continue to pay Part B premium or Medicare premium. MEDIA: Print • TV-Part B caveat must be flashed in TV safe range or mentioned in narration.	• "No premium" • "No premiums or deduetibles" • "Free"	The following may be used. • "No plan premium." • "Plan premium equals _____" • $0 plan premium • "At no extra cost to you" but only if referring to a specific benefit • "No plan premiums or deductibles" • "No premiums or deductibles (you must continue to pay the Medicare Part B premium)" • "No premium beyond your monthly Medicare payment" • "No premiums other than what you currently pay for Medicare MEDIA: All except outdoor advertising (See "Must Use") • "Plan premium" MEDIA: Outdoor. Outdoor advertising has the option of excluding this topic.	• Materials must disclose that beneficiaries must continue to pay the Part B premium and continue their Medicare Part B coverage while enrolled in the HMO. Because of the length of the messages and the nature of outdoor advertising, this topic does not apply to outdoor advertising.
Testimonials	• Content must comply with HCFA marketing guidelines, including statements by members.	• Cannot have non-members say he/she belongs. (Can use actors, but they cannot say they belong to the plan.) • Speaker must identify specific health plan membership MEDIA: All		

MARKETING LANGUAGE: "MUST USE/CAN'T USE/CAN USE" CHART

Subject	Must Use	Can't Use	Can Use	Reason
Contract with the Government	• Must include one of the phrases from the can use column MEDIA: All except outdoor. Outdoor advertising has the option of excluding this topic.	• "Recommended or endorsed by Medicare" • Cannot imply that plan has a unique or custom arrangement with the government, e.g.: – "Special contract with Medicare" – "Special plan for Medicare beneficiaries"	• "HMO with a Medicare contract" • "A federally qualified HMO with a Medicare contract" • "A federally qualified Medicare contracting HMO" • "Medicare approved HMO" MEDIA: All	Because of the length of the messages and the nature of outdoor advertising, this topic does not apply to outdoor advertising.
Physicians and Other Health Care Providers	• If the number of physicians and other health care providers is used, it must include only those available to Medicare beneficiaries MEDIA: TV, radio, outdoor • If the number of physicians and other health care providers is used, it must include only providers available to Medicare beneficiaries. If a total number is used it must separately delineate the number of primary care providers and specialists included. MEDIA: Print and direct mail	• Implication that providers are available exclusively through the particular HMO unless such a statement is true • "Participating providers" unless you use plan name	• "(Plan's name) participating providers" • "Network" providers • "Contracting" providers • "Affiliated" providers • Number of providers should be same total number of Medicare providers MEDIA: All	• Do not use the word "participating" when referring to plan providers (unless you use plan name), since it could be confused with a participation agreement with Medicare. Plans should either use "contracting" or "plan name" when referring to plan providers.
Limited Open Enrollment Period			• Describe open enrollment period if open enrollment is not continuous MEDIA: All	

MARKETING LANGUAGE:
"MUST USE/CAN'T USE/CAN USE" CHART

Subject	Must Use	Can't Use	Can Use	Reason
Eligibility	• Must indicate that all Medicare beneficiaries may apply.	• "No health screening" unless specific mention is made of ESRD and hospice • "Seniors" unless term appears with "and all other Medicare eligibles" • "Plan designed especially for seniors" • "Senior plan" unless part of plan name • "Individuals age 65 and over" • "You must have Parts A and B of Medicare"	• "Anyone with Medicare may apply" • "Medicare entitled" • "Individuals eligible for Medicare" • "Individuals on or entitled to Medicare" • "Medicare beneficiaries" • "Medicare enrollees" • "People with or on Medicare" • "Seniors and all other Medicare-eligibles" • "No physicals required" • "No health screening" if a caveat is included for ESRD and hospice • "If you do not have Medicare Part A, you may purchase Part A coverage from Social Security or purchase equivalent coverage from the HMO" MEDIA: ALL	• Since all Medicare beneficiaries may enroll in Medicare-contracting HMOs, you may not refer to your plan as a "senior plan" (unless you refer to it as part of the plan name). The term "senior plan" implies that disabled beneficiaries may not enroll. • Medicare Part A is not a requirement for enrollment in Medicare-contracting HMOs. Plans may require beneficiaries who are not covered under Part A to purchase equivalent coverage directly from the plan
Claims Forms/ Paperwork		• "No paperwork" • "No claims or paperwork/complicated paperwork" • "No claims forms"	• "Virtually no paperwork" • "No paperwork when using plan providers" • "Hardly any paperwork" MEDIA: All	• Members may be required to submit bills or claims documentation when using out-of-plan providers.

MARKETING LANGUAGE:
"MUST USE/CAN'T USE/CAN USE" CHART

Subject	Must Use	Can't Use	Can Use	Reason
Benefits				
a. Comparison	• If premiums and benefits vary by geographic area, must clearly state this or must clearly state geographic area in which differing premiums and benefits are applicable. • If only benefits vary, clearly state geographic area in which benefits are applicable. MEDIA: All		• "Premiums and benefits may vary by county" or "These benefits apply to the following counties" • "Except for _____ county" MEDIA: All	• Premiums, benefits and /or copayment amounts may vary by county within a given service area. This must be clearly conveyed in all marketing materials.
b. Limitations		• Minimal copays <u>may</u> apply • At no extra cost to you or free, if copays apply	• State exact dollar amount limit on any benefit • "Limitations and restrictions may apply" • "Minimal copayments will apply" • "Minimal copayments may vary by county"	• If benefits are specified within the piece, any applicable copayment should be stated or you may include the general statement as shown.
c. Prescription Drugs	• If prescription drugs are mentioned and have limitaions, must say: • limited drug coverage; • drug coverage benefits subject to limitations; or • up to xxx annual limit or xxx limit per year and other limits and restrictions may apply.	• "We cover prescription drugs" unless accompanied by reference to limitation • "Prescription drug coverage" unless accompanied by reference to limitation	• State which benefits are subject to limitations • Fully disclose dollar amount of copayments and annual limit • If limited, you must say so • Limited drug coverage with xx copayments and xxx annual limit • "Prescriptions must be filled at contracting or plan affiliated pharmacies." MEDIA: All	Prescription drugs are an important benefit that must be adequately described. Any dollar limits must be clearly conveyed.

MARKETING LANGUAGE:
"MUST USE/CAN'T USE/CAN USE" CHART

Subject	Must Use	Can't Use	Can Use	Reason
Definitions		• "Life threatening" • "True emergency"	• Emergency – definition as stated in current HCFA policy. • Urgent – definition as stated in current HCFA policy. MEDIA: Direct mail	• Emergency criteria should be explained per Medicare guidelines rather than in the commercial context.
Drawings/prizes		• "Eligible for free drawing and prizes" MEDIA: Direct mail, flyers, print advertising	• "Eligible for a free drawing and prizes with no obligation" • "Free drawing without obligation" MEDIA: Direct mail, flyers, print advertising.	• It is a prohibited marketing practice to use free gifts and prizes as an inducement to enroll. Any gratuity must be made available to all participants regardless of enrollment. The value of any gift must be less than the nominal amount of $10.
Sales presentations	• "A sales representative will be present with information and applications." MEDIA: Flyers, invitations and print advertising • "A sales representative may call." MEDIA: Response card • A telecommunications device for the deaf (TDD) is available to get additional information or set up a meeting with a sales representative. • For accommodation of persons with special needs at sales meetings, call (Health Plan Phone Number).	• "A plan representative will be available to answer questions."		• This phrase must be used whenever beneficiaries are invited to attend a group session with the intent of enrolling those individuals attending. • This phrase must be included on any response card in which the beneficiary is asked to provide a telephone number.

CHAPTER IV

PROVIDER PROMOTIONAL ACTIVITIES

PROVIDER PROMOTIONAL ACTIVITIES

Some health plans use their plan providers to help them market their Medicare product. As used in this Guide, the term "provider" means all Medicare HMO contracting health care delivery network members; e.g. physicians, hospitals, etc. This goes beyond the Medicare regulatory definition for "provider". Section 2213 of the HMO Manual contains some guidance on this subject. The purpose of this chapter is to remind plans of the manual provisions and to further specify what practices in this area would meet both HCFA requirements and the needs of the plans.

Plans need to ensure that promotional activities conform to the requirements of sections 1128A(a)(5) and 1128B(b) of the Act. Section 1128A(a)(5) of the Act establishes civil monetary penalties for plans that do not comply with the requirements of section 1128B(b). Section 1128B(b), the Medicare and Medicaid anti-kickback statute, prohibits the offering or giving of any remuneration to induce the referral of a Medicare or Medicaid beneficiary, or to induce a person to purchase, order or arrange for, or recommend the purchase or ordering of an item or service paid in whole or in part by the Medicare or Medicaid programs.

Provider Marketing

HCFA strongly discourages provider marketing for the following reasons:

- Providers are usually not fully aware of membership plan benefits and costs;
- Providers may not be the best source of plan membership information for their own patients;
- A provider outside the role of providing medical services may confuse the beneficiary about when the provider is acting as an agent of the plan;
- Providers' knowledge of their patients' health status increases the potential for their discriminating in favor of Medicare beneficiaries with positive health status when acting as a marketing agent. (See section 2211A of the HMO/CMP Manual.) They might also discriminate in favor of beneficiaries with negative health status as a way to reduce beneficiaries' out-of-pocket costs and/or increase benefits.

Listed below are some requirements for the relevant activities associated with provider marketing and the reasons for them:

1. Provider groups can give out health plan brochures (exclusive of applications) at a health fair or in their own offices. The providers or their representatives cannot compare benefits among health plans or take applications unless qualified plan representatives are present. This is because they may not be fully aware of all health plan benefits and costs.

2. Provider groups can co-sponsor an event, e.g., an open house or a health fair with a plan. Provider groups and plans can cooperatively market and advertise by such means as TV, radio, direct mail, testimonials, posters, fliers and print ads. All materials describing the Medicare risk product in any way must get prior approval, should have the plan's name or logo on them as well as the provider group's name or logo, and must follow all of the rules in Chapter III on "Sales Packages and Advertising and Must Use/Can't Use/Can Use Chart." All materials mentioning the risk product are considered marketing materials and must therefore adhere to this Guide and be prior approved by HCFA. **NOTE TO PLAN:** While it is not necessary for provider groups to coordinate such cooperative marketing events with all plans with whom they contract, as a courtesy they may wish to do so.

3. Provider groups can announce a new affiliation with a health plan to their patients. An announcement of a new affiliation provider, naming only one plan to a patient, may occur only once. Additional marketing contacts with the provider's patients must include information on all the Medicare plans with which the provider contracts including annual affiliation announcements. If these communications describe the Medicare risk product in any way, they must be prior approved by HCFA and an assurance must be given that the groups will not health screen when sending out such information to their patients. The reason for this is that any material sent to beneficiaries that talks about the Medicare risk product is marketing and health screening is a prohibited marketing activity.

4. Provider groups can furnish a complete list of Medicare eligible patients to a health plan. They cannot disclose coverage, age, or health status; furnish other HMO's membership lists to any plan; and they cannot take applications in their offices. This is because their interests in promoting one plan over another may not always mirror the beneficiaries' interests and providers may not always be fully aware of all membership health plan benefits and costs.

5. Provider groups may send out information to their patients listing the HMOs they contract with and/or comparing the benefits of the different health plans with which they contract. Such materials must have the concurrence of all plans involved and must be prior approved by HCFA. The plans may want to determine a lead HMO to coordinate submission of these materials. HCFA continues to hold the plans responsible for any marketing material developed and distributed on their behalf by their contracting medical groups and other health care providers. Also, physician groups may not always be fully aware of all health plans' membership benefits and costs.

Please advise your health plan provider groups of the provisions of these rules.

CHAPTER V

MODEL ENROLLMENT, DENIAL OF ENROLLMENT, AND DISENROLLMENT LETTERS

MODEL ENROLLMENT, DENIAL OF ENROLLMENT, AND DISENROLLMENT LETTERS

The attached model letters may be modified to meet health plan policies and procedures. For example, health plans may mail out the membership card and EOC or Subscriber Handbook with the first letter, the confirmation letter, or with an additional letter. To help plans that do not want to use the exact model letters attached, each health plan must submit a checklist with each letter. This will ensure that the plan covers all of the required notification information. Sample checklists can be found at the end of this chapter.

Beneficiaries who apply for membership in a risk HMO/CMP must be notified in writing of the acceptance or denial of their applications. Proposed enrollments must be forwarded to HCFA within 30 days from the time the application is received or the date a vacancy occurs for an applicant who was accepted while the organization was enrolled to capacity (42 CFR 417.430, and HMO/CMP Manual Section 2001.6).

For enrollment, two notices are generally required. The first notice is sent within 30 days of receipt of the application. The notice informs the beneficiary of the steps in the processing of the application (see Model A-1). The second notice is sent after the reply list is received from HCFA that confirms or rejects the beneficiary's enrollment in the plan (see Model A-4). In no case should a plan confirm an effective date under the Medicare contract before acceptance of the enrollment is received from HCFA.

Plans frequently become confused about what notice to send when HCFA rejects the enrollment for no Part B entitlement or ESRD status, and the health plan has verification of Part B entitlement from Litton, CompuServ, or the Social Security Administration (SSA). Plans may correctly deny the enrollment and refer the beneficiary to SSA for correction of the health insurance entitlement information (see Model A-3). If the beneficiary is able to get the record corrected, the plan may resubmit the record with a new effective date.

Health plans offering services under Medicare FFS prior to the effective date of enrollment under the Medicare contract may use Model letter A-2.

Finally, HCFA requires plans to keep a record of the date and content of letters. Electronic records are acceptable if the plan does not want to retain hardcopies.

As long as microfilm versions of the enrollment application forms and disenrollment requests showing the signature and the date are available to reviewers, it is appropriate to allow for storage on microfilm. Similarly, other technologies that allow the reviewer to access signed and dated forms may also be allowed, such as optically scanned forms stored on disk.

For information on effective date of enrollment and how to handle delays in enrollment due to SSA/HCFA or plan error, see SECTION 2002 of the HMO/CMP manual.

A Medicare beneficiary's enrollment begins with the first day of the month in which his/her membership in the HMO/CMP is effective, as shown on HCFA's records. In no case may the plan enroll a beneficiary effective earlier than the month after, or later than the third month after, the month in which the enrollment information is correctly submitted and received by HCFA.

You are responsible for submitting to HCFA correct and timely records for new enrollments. In general, HCFA does not accept records that are:

- received after the monthly cut-off date for submission of records, as announced by HCFA periodically, or
- incomplete or incorrect.

I. SSA/HCFA ERROR (Section 2002.1.B)--Request a retroactive enrollment for any SSA/HCFA systems problem which delay processing of applications. These include: 1) if a beneficiary's enrollment application was rejected because Part B entitlement is not reflected on Medicare records prior to the first month of entitlement (because there is often a lag period when an individual enrolls during a special enrollment period at the time of retirement instead of the initial enrollment period at age 65), 2) Health Insurance Claim number changes, 3) erroneous death notifications, 4) problems with posting of premiums, or 5) any other SSA/HCFA systems issue which may cause Medicare entitlement data to be incorrect or missing.

NOTE TO PLAN: You may wish to refer to Section 2002 of the HMO/CMP manual regarding other types of retroactive enrollments to address other situations, such as employer group enrollments (Section 2002.A), conversions and enrollment prior to Part B entitlement (Section 2002.B), and disability cessations (Section 2002.1.A).

II. PLAN ERROR (Section 2002)--If you have informed a beneficiary that his/her enrollment in your organization is effective as of a certain date, but you then submit an incorrect enrollment record to HCFA, you must honor your contract with the enrollee and begin providing coverage on the stated date.

- If you provide services to the enrollee before you can submit the correct enrollment information, you may still receive Medicare FFS payment for any services you render. In order for you to receive direct payments for physician and supplier services from a Medicare carrier, you must have a third party billing number. (See Medicare Carriers Manual Sections 7065 and 3060.)
- If you collect, or have waived collection of a premium from the beneficiary which covers the deductible and coinsurance for Medicare covered services for the originally designated month of enrollment, you are financially responsible for Medicare deductibles and coinsurance amounts not paid by carriers and intermediaries on pre-enrollment claims for services obtained in plan or for emergency or urgently-needed care.

- The Medicare beneficiary is liable for any copayments you impose for services, and is liable for deductible and coinsurance amounts for any services for which you have no financial responsibility under the terms of your contract with the beneficiary.

Beneficiary Guardian Signature Issue

An individual beneficiary is generally the only person who may execute a valid application in an HMO/CMP or request for disenrollment from an HMO/CMP. (See OPL 95.007 (revised) which discusses signatures on enrollment/disenrollment forms.)

When someone other than the beneficiary completes an enrollment application or disenrollment request, be sure to keep documentation showing how the determination was made and that another individual was authorized to enroll or disenroll the beneficiary.

NOTE: Plans may continue to use current stocks of approved applications materials.

Definitions of EBMF: An EBMF may be any of the following:

(A) A specifically designed enrollment application form which is attached to plan marketing materials.

(B) A standard plan enrollment application form with instructions that the form must be mailed back to the health plan.

(C) A mailing card that requests the health plan to send the beneficiary a standard enrollment application form.

NOTE TO PLAN: The key feature of the EBMF is that it must be completed by the beneficiary in the absence of plan marketing influences and returned to the health plan by mail. (Self-addressed, postage paid, return envelopes may be provided by the plan.)

MEDICARE RISK CONTRACTORS
MODEL (HEALTH PLAN NAME) ENROLLMENT APPLICATION FORM

NOTE TO PLAN: This application is currently under revision. A revised copy is forthcoming.

SUMMARY OF MODEL ENROLLMENT LETTERS

Letter	Title	Check List
A-1	Proposed Enrollment Effective Date	I
A-2	Receipt of Medical Services Under Medicare FFS Prior to Enrollment	II
A-3	Deny Enrollment	III
A-4	Confirm Enrollment Effective Date	IV

SUMMARY OF MODEL DISENROLLMENT LETTERS

Letter	Title	Check List
B-1	Sending Out Disenrollment Form	V
B-2	Disenrollment Confirmation	VI
B-3	Disenrollment Confirmation	VI
B-4	Confirmation of Disenrollment Date	VI
B-5	Failure to Pay Plan Premium --Advance Notification Regarding Reduction in Coverage	VII
B-6	Failure to Pay Plan Premium --Reduction in Coverage	VIII
B-7	Failure to Pay Plan Premium --Involuntary Disenrollment	IV
B-8	Failure to Pay Plan Premiums --Confirmation of Involuntary Disenrollment	

MODEL ENROLLMENT LETTER A-1
PROPOSED ENROLLMENT EFFECTIVE DATE

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

We have received your application for enrollment in (Health Plan Name.)

Your proposed enrollment date of (Effective Date) is subject to confirmation of Medicare eligibility by the Health Care Financing Administration (HCFA), the Federal Agency that administers the Medicare and Medicaid Programs. Upon confirmation by HCFA, we will notify you in writing of your effective date of enrollment as a member of (Health Plan Name) and we will send you a (Health Plan Name) identification card. If eligibility is denied, we will notify you in writing of the reason for the denial.

Until you are notified that your eligibility is confirmed and an effective date is assigned, you are not eligible for benefits under (Health Plan Name.) Please continue to obtain your health care services under your current Medicare arrangement or with your current Health Maintenance Organization.

After your enrollment is effective, all care, except for emergency care and out-of-area urgently-needed care, must be performed or arranged by a (Health Plan Name) doctor and in a (Health Plan Name) designated hospital or other health facility. All care includes home health services and durable medical equipment.

(For contractors with "point-of-service" (POS) benefit feature or Visitors Program: List plan-specific requirements and level of coverage found in your Evidence of Coverage.)

(For "Cost" Contractors: After your enrollment is effective, in order for (Health Plan Name) to fully pay for medical services for you, these services (except for emergency and out-of-area urgently-needed services) must be provided or arranged by (Health Plan Name). You may receive services that are not provided or arranged by (Health Plan Name), but you will be responsible for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare Program. You may be liable for any charges not covered by the Medicare Program.) **NOTE TO PLAN:** Be sure to offer adequate explanation of Medicare card use with out-of-plan utilization which is not an emergency or urgently-needed service.

If you have any questions regarding your pending eligibility or the above verification process, please contact our Member Services Department, Monday through Friday (Hours of Operation) at (Health Plan Phone Number.) We will be happy to assist you.

Sincerely,

Plan Representative

MODEL LETTER A-2
RECEIPT OF MEDICAL SERVICES UNDER
MEDICARE FFS PRIOR TO ENROLLMENT

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

We are pleased you have selected (Health Plan Name) for your health care needs and are confident that your association with us will be long and happy. Your proposed enrollment date of (Effective Date) is subject to confirmation of Medicare eligibility by the Health Care Financing Administration (HCFA). Upon confirmation from HCFA, we will notify you in writing of your effective date. If eligibility is denied we will notify you in writing about the reason for denial.

Until your effective date, you should continue to receive your health care services under your current Medicare fee-for-service arrangements. If you wish to receive services from a (Health Plan Name) physician, you may receive those services under the Medicare fee-for-service program. This means that you will be responsible for all coinsurance and deductibles that apply under regular Medicare. However, if you are a member of another health maintenance organization, you **must** continue to use that organization until your membership in (Health Plan Name) is effective.

As of your effective date, you must obtain ALL of your routine health care from (Health Plan Name) physicians. If you seek health services from non-(Health Plan Name) physicians, other than for emergencies or out-of-area urgent care, without prior authorization from (Health Plan Name), you will be responsible for all costs incurred.

(For contractors with a "point of service" (POS) benefit feature or Visitors Program: List plan specific requirements and level of coverage found in your EOC.)

(For "Cost" Contractors: After your enrollment is effective, in order for (Health Plan Name) to fully pay for medical services for you, these services (except for emergency and out-of-area urgently-needed services) must be provided or arranged by (Health Plan Name). You may receive services that are not provided or arranged by (Health Plan Name), but you will be responsible for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare Program. You may be liable for any charges not covered by the Medicare Program.) **NOTE TO PLAN:** Be sure to offer adequate explanation of Medicare card use with out-of-plan utilization which is not an emergency or urgently-needed service.

If you have any questions about your enrollment, you may contact our Member Services Department, Monday through Friday, (Hours of Operation) at (Health Plan Phone Number.) Thank you for your upcoming membership in (Health Plan Name.)

Sincerely,

Plan Representative

MODEL LETTER A-3
DENY ENROLLMENT

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

We thank you for your recent application to (Health Plan Name.) We are unable to accept your application for enrollment in (Health Plan Name) due to the reason indicated below.

_____ You are currently participating in a Medicare-certified hospice plan (program for the terminally ill).

_____ You have End Stage Renal Disease (ESRD) or you have had a kidney transplant within the past 36 months.

_____ You are not enrolled in Medicare Part B.

_____ You reside outside our service area.

_____ Your application was not signed by you (the applicant), or a court-appointed guardian.

If the information indicated above is incorrect or you have any questions, please notify our Member Services Department, Monday through Friday, (Hours of Operation) at (Health Plan Phone Number). Thank you for your cooperation.

Sincerely,

Plan Representative

MODEL LETTER A-4
CONFIRM ENROLLMENT EFFECTIVE DATE

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

Your eligibility for Medicare coverage under (Health Plan Name) has been confirmed by the Health Care Financing Administration, the Federal Agency that administers the Medicare and Medicaid Programs. Your enrollment with (Health Plan Name) is effective on (Confirmed Effective Date.) You will receive a (Health Plan Name) Identification Card soon if you have not already received one in the mail.

Until the effective date, your care will be provided by your existing program. On or after the above date, all care, except for emergency and urgently-needed out-of-area care, must be provided or arranged by a (Health Plan Name) physician and in a (Health Plan Name) designated hospital or other health facility. If you receive care outside the (Health Plan Name) Medicare network, you will be responsible for payment of the care. Neither Medicare or (Health Plan Name) will pay for care provided outside the health maintenance organization Medicare network.

(For contractors with a "point-of-service" (POS) benefit feature or Visitors Program: List plan-specific requirements and level of coverage found in your EOC.)

(For "Cost" Contractors: After your enrollment is effective, in order for (Health Plan Name) to fully pay for medical services for you, these services (except for emergency and out-of-area urgently-needed services) must be provided or arranged by (Health Plan Name). You may receive services that are not provided or arranged by (Health Plan Name), but you will be responsible for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare Program. You may be liable for any charges not covered by the Medicare Program.) **NOTE TO PLAN:** Be sure to offer adequate explanation of Medicare card use with out-of-plan utilization which is not an emergency or urgently-needed service.

After your effective date and before you receive your (Health Plan Name) Identification Card, you should use this letter in place of the Identification Card when seeking medical services from a (Health Plan Name) provider or participating pharmacy. (A reference to participating pharmacy is required only where plans have arrangements with pharmacies for prescription drug coverage.)

If you have any questions regarding your effective date of enrollment, please contact our Member Services Department, Monday through Friday (Hours of Operation) at (Health Plan Phone Number). We will be happy to assist you.

Sincerely,

Plan Representative

HEALTH CARE PLAN
MODEL REQUEST FOR DISENROLLMENT FORM

NOTE TO BENEFICIARY: If you have recently joined or intend to join a health maintenance organization, you do not have to complete this form.

DATE_____

(Please Print In Ink)
MEMBER'S NAME_____
First Middle Last

ADDRESS_____
City State Zip Code County

TELEPHONE (____)_____

MALE _____ FEMALE_____ DATE OF BIRTH_____

MEDICARE #_____

DISENROLLMENT RESPONSIBILITIES:

Please carefully read and complete the information below before signing and dating the disenrollment form.

NOTE TO BENEFICIARY: Upon the effective date of enrollment in another health maintenance organization, your current membership in (Health Plan Name) will automatically be canceled.

Disenrollment from the (Health Plan Name) will be effective on the first day of the month after the month (Health Plan Name) receives the written request (unless you request a later date of disenrollment). For example, if you complete this form and give it to (Health Plan Name) on April 30, the last day of the month, your disenrollment will be effective the next day, May l.

Members who have requested disenrollment must continue to receive all medical care from (Health Plan Name) until the effective date of disenrollment.

Requested disenrollment date:_____

_____ _____
Beneficiary Signature Date

or

_____ _____
Beneficiary Guardian Signature Date

MODEL LETTER B-1
SENDING OUT DISENROLLMENT FORM

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

I am enclosing a disenrollment form at your request. Please complete the entire form as highlighted, sign it, and return it to us in the enclosed envelope or mail it to your local Social Security Office or Railroad Retirement Board Office. **NOTE TO BENEFICIARY:** As long as signature and date are readable, facsimile transmission is permissible.

Your disenrollment is effective the first of the month following the month we receive this completed and signed form, (unless you have requested a later date). You must continue to use (Health Plan Name) providers until your disenrollment date. Disenrollment signifies that you are dropping your membership in (Health Plan Name).

We will mail a copy of the disenrollment form back to you with the effective date of your disenrollment noted on the form.

(Health Plan Name) strives to provide quality health care coverage and service to our members and we will continue our efforts in this direction. Thank you for giving us the opportunity to address your health care needs. If you require further assistance, please contact our Member Services Department, Monday through Friday, (Hours of Operation) at (Health Plan Phone Number).

Sincerely,

Plan Representative

MODEL LETTER B-2
DISENROLLMENT CONFIRMATION

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

Enclosed is a copy of your signed disenrollment form. As you requested, we have processed your disenrollment to be effective (Effective Date of Disenrollment).

Please note that if you are currently a (Health Plan Name) member, you must continue to use (Health Plan Name) providers until your disenrollment date. After that date you will be able to see the provider of your choice through fee-for-service Medicare, unless you have enrolled in another Medicare-contracting health maintenance organization.

Please be patient. It will take a few weeks to process your disenrollment and to update Medicare's records so that your regular, fee-for-service claims will clear for payment. You may wish to inform provider(s) who submit claims to Medicare for payment that there could be a short-term delay.

Thank you for allowing us to assist you in this process. If you have additional questions, please feel free to contact our Member Services Department Monday through Friday (Hours of Operation) at (Health Plan Phone Number).

Sincerely,

Plan Representative

MODEL LETTER B-3
DISENROLLMENT CONFIRMATION

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

We have received your signed disenrollment form requesting to be disenrolled from (Health Plan Name). As you requested, we have processed your disenrollment to be effective (Effective Date of Disenrollment).

Please note that until the disenrollment date referenced above, you must continue to use (Health Plan Name) providers except for emergencies or out-of-area urgent care. After that date you will be able to see the provider of your choice through fee-for-service Medicare, unless you have enrolled in another Medicare contracting health maintenance organization.

Please be patient. It will take a few weeks to process your disenrollment and to update Medicare's records so that your regular, fee-for-service claims will clear for payment. You may wish to inform provider(s) who submit claims to Medicare for payment during that period that there could be a short-term delay.

Thank you for allowing us to assist you in this process. If you have any additional questions, please feel free to contact our Member Services Department, Monday through Friday, (Hours of Operation) at (Health Plan Phone Number).

Sincerely,

Plan Representative

MODEL LETTER B-4
CONFIRMATION OF DISENROLLMENT DATE

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

Your disenrollment form was submitted to the Health Care Financing Administration, the Federal Agency that administers the Medicare and Medicaid Programs, and we have received confirmation that your disenrollment is effective (Effective Disenrollment Date).

Please note that if you are currently a (Health Plan Name) member, you must continue to use (Health Plan Name) providers, except for emergencies and out-of-area urgent care, until (Effective Disenrollment Date). After that date you will be able to see the provider of your choice through fee-for-service Medicare, unless you have enrolled in another Medicare contracting health maintenance organization.

Please be patient. It will take a few weeks to process your disenrollment and to update Medicare's records so that your regular, fee-for-service claims will clear for payment. You may wish to inform provider(s) who submit claims to Medicare for payment that there could be a short-term delay.

Thank you for allowing us to assist you in this process. If you have any additional questions, please feel free to contact our Member Services Department, Monday through Friday, (Hours of Operation) at (Health Plan Phone Number).

Sincerely,

Plan Representative

MODEL LETTER B-5
FAILURE TO PAY PLAN PREMIUMS --
ADVANCED NOTIFICATION OF
REDUCTION IN COVERAGE

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

According to our records we have not received payment for your plan premium as of (date). If we do not receive payment, we will have no choice but to downgrade your membership in (Health Plan Name). What this means is that (Describe lower level of benefits, e.g., prescription drugs or routine dental care will not be covered) from (Date).

If you wish to disenroll from (Health Plan Name), you must complete the enclosed disenrollment form and send it to us at the following address:

(Health Plan Address)

Please note that unless you disenroll from (Health Plan Name) you must continue to use (Health Plan Name) providers except for emergency or out-of-area urgently needed care.

If you believe that we have made a mistake or if you have any questions, please contact our Member Services Department, Monday through Friday, (Hours of Operation) at (Health Plan Phone Number).

Sincerely,

Plan Representative

Enclosure

MODEL LETTER B-6
FAILURE TO PAY PLAN PREMIUMS --
REDUCTION IN COVERAGE

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

We recently notified you in a letter dated (Date) that your plan premium was overdue and that if we did not receive it, we would have no choice but to reduce your coverage in (Health Plan Name) effective (Date). Regretfully, since we did not receive that premium (amount owed), we have downgraded you to (Health plan's lower level of benefits). What this means is that (Describe lower level of benefits, e.g., prescription drugs or routine dental care will not be covered) from (Date).

You have the right to request a review of this decision through the grievance procedure outlined in your Member Handbook.

If you wish to disenroll from (Health Plan Name), you must complete the enclosed disenrollment form and send it to us at the following address:

(Health Plan Address)

Please note that unless you disenroll from (Health Plan Name) you must continue to use (Health Plan Name) providers except for emergency or out-of-area urgently needed care.

If you believe that we have made a mistake or if you have any questions, please contact our Member Services Department, Monday through Friday, (Hours of Operation) at (Health Plan Phone Number).

Sincerely,

Plan Representative

MODEL LETTER B-7
FAILURE TO PAY PLAN PREMIUM--
INVOLUNTARY DISENROLLMENT

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

We recently notified you in a letter dated (Date) that your plan premium was overdue and that if we did not receive it, we would have no choice but to disenroll you from membership in (Health Plan Name). Regretfully, since we did not receive that premium (amount owed), we have, requested the Health Care Financing Administration to disenroll you from (Health Plan Name) effective (Date).

You have the right to request a review of this decision through the grievance procedure outlined in your Member Handbook.

Please note that until the disenrollment date referenced above, you must continue to use (Health Plan Name) providers except for emergency or out-of-area urgently needed care. After that date, you will be able to see the provider of your choice through fee-for-service Medicare, unless you have enrolled in another Medicare contracting health maintenance organization.

If you believe that we have made a mistake or if you have any questions, please contact our Member Services Department, Monday through Friday, (Hours of Operation) at (Health Plan Phone Number).

Sincerely,

Plan Representative

MODEL LETTER B-8
FAILURE TO PAY PLAN PREMIUM--
CONFIRMATION OF INVOLUNTARY DISENROLLMENT

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

We have received confirmation from the Health Care Financing Administration, the Federal Agency that administers the Medicare and Medicaid Programs, of your disenrollment from (Health Plan Name) due to non-payment of plan premium. Your disenrollment is effective as of (Effective Date).

You have the right to request a reconsideration of this action through the grievance procedure outlined in your Member Handbook.

If you have any questions regarding this action, or need assistance in any way, please do not hesitate to call our Member Services Department, Monday through Friday, (Hours of Operation) at (Health Plan Number).

Sincerely,

Plan Representative

CHECKLIST I
FOR FIRST ENROLLMENT LETTER
MODEL LETTER A-1

1.	Effective date	¶ _____	Line _____
2.	Enrollment submitted to HCFA	¶ _____	Line _____
3.	How member accesses care prior to effective date	¶ _____	Line _____
4.	How member accesses care after effective date (lock-in provisions)	¶ _____	Line _____
5.	Health plan's responsibility to notify beneficiary of HCFA's response	¶ _____	Line _____
6.	Membership card information	¶ _____	Line _____
7.	Health plan contact and telephone information	¶ _____	Line _____
8.	Copy of enrollment application if not already given	¶ _____	Line _____

CHECKLIST II
FOR CONFIRMATION LETTER
MODEL LETTER A-2

1.	Effective date	¶ _____	Line _____
2.	How member accesses care after the effective date	¶ _____	Line _____
3.	Membership card information (if not already sent)	¶ _____	Line _____
4.	Health plan contact and telephone number	¶ _____	Line _____

CHECKLIST III
FOR DENIAL LETTER
MODEL LETTER A-3

1.	Reason for Denial	¶ _____	Line _____
2.	Contact SSA for entitlement problems	¶ _____	Line _____
3.	Health plan contact and telephone	¶ _____	Line _____

CHECKLIST V
FOR SENDING OUT DISENROLLMENT FORM LETTER
MODEL LETTER B-1

1.	How to complete form	¶ _____	Line _____
2.	Disenrollment date	¶ _____	Line _____
3.	Using plan providers until disenrollment is effective	¶ _____	Line _____
4.	Health plan contact and telephone information	¶ _____	Line _____

CHECKLIST VI
FOR DISENROLLMENT CONFIRMATION LETTER
MODEL LETTERS B-2, B-3 AND B-4

1.	Disenrollment date	¶ _____	Line _____
2.	Copy of disenrollment form	¶ _____	Line _____
3.	Using health plan providers until disenrollment is effective	¶ _____	Line _____
4.	Updating Medicare records	¶ _____	Line _____
5.	Health plan contact and telephone information	¶ _____	Line _____

CHECKLIST VII
FOR FAILURE TO PAY PLAN PREMIUMS
MODEL LETTERS B-5, B-6, B-7 AND B-8

1.	Disenrollment date	¶ _____	Line _____
2.	Using plan providers until disenrollment is effective	¶ _____	Line _____
3.	Health plan contact and telephone information	¶ _____	Line _____

CHAPTER VI

MODEL
EVIDENCE OF COVERAGE

INTRODUCTION

Many health plans have requested help in drafting membership rules for Medicare risk contracts. In response to these requests, this chapter provides a model Evidence of Coverage (EOC) also known as member contract or subscriber agreement. Instead of listing benefits separately, plans can use the Model Summary of Benefits as outlined in Chapter 8. Please note that this chapter provides a model and health plans are free to develop their own language. However, approval will be expedited for those plans choosing to use the model language.

To further expedite review and approval, the Completeness Checklist at the end of this chapter must be completed for all EOCs and other documents regarding membership rules submitted to the HCFA regional office (RO). In addition, it will simplify RO review if you will highlight any changes you are making from your previously approved EOC.

REFERENCE SHEET FOR CHAPTER VI
MODEL EVIDENCE OF COVERAGE

WELCOME TO (Health Plan Name)!

Your contract for membership in (Health Plan Name) consists of this Evidence of Coverage (EOC), your enrollment form, and any amendments that may be added in the future. It is an explanation of your rights, benefits, and responsibilities as a (Health Plan Name) member. It also explains (Health Plan Name)'s responsibilities to you.

This EOC contains important information. PLEASE READ IT CAREFULLY. Keep it in a safe place, available for quick reference.

(Health Plan Name) is not an insurance policy that merely pays Medicare deductible and coinsurance charges (commonly called a "Medigap" or "Medicare supplement" policy). Instead, (Health Plan Name) has entered into a contract with the Health Care Financing Administration (HCFA), the Federal Agency that administers the Medicare and Medicaid Programs. Under this contract, HCFA makes a monthly payment to (Health Plan Name) for each Medicare beneficiary who enrolls in our plan. This contract requires (Health Plan Name) to provide comprehensive health services to persons who are entitled to Medicare benefits and who choose to enroll in (Health Plan Name). (Health Plan Name) covers all services and supplies offered by Medicare, (optional, varying by plan: plus some services and supplies not covered by Medicare).

Even though HCFA pays (Health Plan Name) a monthly payment to provide or arrange for all of your Medicare covered services, you are still responsible for payment of your Medicare Part B premium after you join (Health Plan Name). This is the premium that is required to maintain your enrollment in Medicare's Medical Insurance Program, also known as Medicare Part B. The health plan premium you pay to (Health Plan Name), if any, covers Medicare deductible and coinsurance costs. (Optional, varying by plan: This premium also includes the benefits (Health Plan Name) provides which are not covered by Medicare).

BY ENROLLING IN (HEALTH PLAN NAME), YOU HAVE MADE A DECISION TO RECEIVE ALL OF YOUR MEDICAL CARE THROUGH (HEALTH PLAN NAME)'s DOCTORS AND HOSPITALS. You must follow this rule for (Health Plan Name) to pay for the health care services you receive. Of course, if you need emergency care (anywhere in the United States, or in certain circumstances at Mexican or Canadian hospitals), or urgent care when out of the service area, those services provided by non-plan providers will be covered by (Health Plan Name). Any other care you receive from non-plan providers (unless arranged by (Health Plan Name)), will not be covered by Medicare or (Health Plan Name) and you will be completely responsible for payment for these services. If you have any questions about (Health Plan Name)'s network of providers or if you would like a list of physicians, physicians' hospital admitting privileges or physician availability, please call our Member Service Department at 1-800-xxx-xxxx.

(For contractors with "point-of-service" POS benefit feature or Visitors Program: List plan-specific requirements and level of coverage found in your EOC.)

(For "Cost" Contractors: After your enrollment is effective, in order for (Health Plan Name) to fully pay for medical services for you, these services (except for emergency and out-of-area urgently-needed services) must be provided or arranged by (Health Plan Name). You may receive services that are not provided or arranged by (Health Plan Name), but you will be responsible for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare Program. You may be liable for any charges for services not covered by the Medicare Program.) **NOTE TO PLAN:** Be sure to offer adequate explanation of Medicare card use with out-of-plan utilization which is not an emergency or urgently-needed service.

(Health Plan Name)'s contract with HCFA is renewed on an annual basis. At the end of each contract year, the contract can be ended by either (Health Plan Name) or HCFA. If the contract ends for any reason, you would receive notice 60 days before the end of the contract. We will explain what your options are at that time. For example, there may be other health plans in the area you can join, if you wish. Or you may wish to return to fee-for-service Medicare and possibly obtain supplemental health insurance. (Health Plan Name) will provide or arrange for supplemental coverage that you may purchase for coverage related to a pre-existing condition for six months or for the duration of any exclusion period that might apply, whichever is shorter. Whether or not you enroll in another prepaid health plan or not, your coverage in the Medicare program will continue. Until the effective date of your disenrollment, you will still be a member of (Health Plan Name).

As a member of (Health Plan Name), there are important rules you must understand regarding how you obtain health care services.

It is important to NOT use your Medicare card, but to use only your (Health Plan Name) membership card for these reasons:

1. to prevent your receiving medical services from non-plan providers in error,
2. in an emergency, to alert hospital staff of the need to notify (Health Plan Name) as soon as possible so that (Health Plan Name) is involved in the management of your care, and
3. to prevent errors in billing. ((Health Plan Name) pays for medical services on behalf of Medicare. Medicare will not pay for medical services while you are a member of (Health Plan Name).)

For specific information about any aspect of your membership in (Health Plan Name), please call our Member Services Department, Monday through Friday, (Hours of Operation) at (Health Plan Phone Number).

For information on your rights, responsibilities and benefits, you may call us or the Medicare Hotline number at 1-800-638-6833, or TTY 1-800-820-1202.

Sincerely,

Plan Representative

SECTION 1
DEFINITIONS

The following definitions apply to the Evidence of Coverage:

BASIC BENEFIT PACKAGE - All health care services that are covered under the Medicare Part A program, Part B program, additional services funded from savings, and mandatory supplemental services, except hospice services.

BENEFIT PERIOD - A benefit period is a way of measuring your use of services under Medicare Part A. A benefit period begins with the first day of a Medicare covered inpatient hospital stay and ends when you have been out of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row (including the day of discharge).

COPAYMENT - A fee payable by a member to a (Health Plan Name) affiliated provider at the time of services.[1]

COVERED SERVICES - Those benefits, services, and supplies for which (Health Plan Name) must pay or provide while you are a member.

CUSTODIAL CARE - Care is considered custodial when it is primarily for the purpose of helping you with daily living or meeting personal needs and could be provided safely and reasonably by people without professional skills or training. Much of the care provided in nursing homes to people with chronic, long-term illness or disabilities is considered custodial care. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine. **Medicare does not pay for custodial care when that is the only care needed.** Even if you are in a participating hospital or skilled nursing facility, Medicare does not cover your stay if you need only custodial care.

DURABLE MEDICAL EQUIPMENT - Equipment which can withstand repeated use; is primarily and usually used to serve a medical purpose; is generally not useful to a person in the absence of illness or injury; and is appropriate for use in the home. To be covered, the item must be prescribed by a (Health Plan Name) physician for use in your home. Examples include oxygen equipment, wheelchairs, hospital beds, and other items that (Health Plan Name) determines are medically necessary, in accordance with Medicare law, regulations and this Guide.

EFFECTIVE DATE - The date, as shown in (Health Plan Name) records and on your (Health Plan Name) membership card, on which (Health Plan Name) coverage begins for you under this contract. You will receive written notification of your effective date once (Health Plan Name) has submitted and confirmed your enrollment with the Health Care Financing Administration.

EMERGENCY SERVICES - Covered inpatient or outpatient services that are furnished in or outside the service area and: (a) are needed immediately because of an injury or sudden illness,

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1 If applicable.

and (b) the time required to reach (Health Plan Name's) providers (or providers authorized by (Health Plan Name)), may have meant risk of permanent damage to your health. See SECTION 6: Emergency and Urgently-Needed Care.

EVIDENCE OF COVERAGE - This document which explains the services and benefits covered by (Health Plan Name) and defines the rights and responsibilities of the member and the Health plan. (May also be called member contract.)

EXCLUSIONS - Items or services which are not covered under this Evidence of Coverage.

EXPERIMENTAL PROCEDURES AND ITEMS - Items and procedures determined by Medicare not to be generally accepted by the medical community. When making a determination as to whether a service is experimental, (Health Plan Name) will use the Guide if available and applicable or rely upon determinations already made by Medicare. Experimental procedures and items are not covered under this contract. **(NOTE TO PLAN:** If you offer any services that are experimental, qualify it here). The plan might want to insert their own criteria for determining coverage of experimental procedures and items not already addressed by Medicare.

FEE-FOR-SERVICE MEDICARE - A payment system by which doctors, hospitals and other providers are paid a specific amount for each service performed as it is rendered and identified by a claim for payment. (Also known as traditional and/or regular Medicare.)

HCFA - The Health Care Financing Administration, the Federal Agency responsible for administering the Medicare and Medicaid Programs.

HEALTH PLAN PROVIDER - Although "provider" is a term the Medicare statute uses to refer to hospitals, nursing homes, and home health agencies only, for the purpose of this Evidence of Coverage, the term means a health professional, a supplier of health care items, or a health care facility having an agreement with (Health Plan Name) to provide medical services to (Health Plan Name) members.

HOME HEALTH AGENCY - A Medicare-certified agency which provides intermittent skilled nursing services and other therapeutic services in your home when medically necessary, when you are confined to your home, and when authorized by your physician.

HOSPICE - An organization or agency, certified by Medicare, that is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill people and their families.

HOSPITAL - An institution which provides inpatient, outpatient, emergency, diagnostic, and therapeutic services. The term "hospital" does NOT include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in routines of daily living.

LOCK-IN - Under this contract you, the member, are "locked-in" to the use of (Health Plan Name) providers. All health care (other than emergencies anywhere in the United States and in certain Mexican or Canadian hospitals or urgently needed services when you are temporarily outside the (Health Plan Name) services area) must be provided or authorized by (Health Plan Name). The use of non-plan providers, except in the emergency or urgent situations mentioned above, or when authorized by your specific health plan benefit package, will result in your obligation to pay for routine care. NEITHER (HEALTH PLAN NAME) NOR MEDICARE WILL PAY FOR THESE SERVICES. (Not included in EOC for cost contractors.)

MEDICALLY NECESSARY - Treatment for a particular condition, determined by (Health Plan Name), to be required and appropriate in accordance with acceptable standards of medical practice.

MEDICARE - The Federal Government health insurance program established by Title XVIII of the Social Security Act.

MEMBER - You, the Medicare beneficiary, entitled to receive health care services under the terms of this (Health Plan Name) Evidence of Coverage, who have voluntarily elected to enroll and whose enrollment in (Health Plan Name) has been confirmed by HCFA.

PART B PREMIUM - A monthly premium paid (usually deducted from a person's Social Security check) to cover Part B services in fee-for-service Medicare. Members of Medicare managed care plans must also pay this premium to receive full coverage and be eligible to join and stay in a managed care plan.

PEER REVIEW ORGANIZATION - Entities paid by HCFA to review medical necessity, appropriateness and quality of medical care and services of provided to Medicare beneficiaries.

PLAN - Health Plan Name

PLAN PHYSICIAN - See *Health Plan Provider* above.

PREMIUM - The (monthly/quarterly) payment to (Health Plan Name) that, along with your Part B premium paid to Medicare, entitles you, the member, to the benefits outlined in this contract.

PRESCRIPTION BENEFIT MANAGER - Firms that contract with plans to manage pharmacy services.

PRIMARY CARE PHYSICIAN (PCP) - A (Health Plan Name) physician who is selected by you, the member, to be responsible for providing or authorizing the health services covered under this contract. The PCP may be a Family Practitioner, General Practitioner or an Internist (Varies by Plan: gynecologist).[1]

PRIOR AUTHORIZATION - A system whereby a provider must receive approval from a staff member of the health plan; e.g., the Health Plan Medical Director, before you, the member, receive certain health care services.

REFERRAL PROVIDER - Any doctor to whom a member is specifically referred for health services (Optional, depending on plan's referral procedures: by a PCP.) Plans must disclose procedures for seeking specialty care.

SERVICE AREA - The area within which a person must live to be able to become or remain a member of (Health Plan Name).

SKILLED NURSING CARE - Services that can only be performed by, or under the supervision of, licensed nursing personnel.

SKILLED NURSING FACILITY - A facility which provides inpatient skilled nursing care, rehabilitation services or other related health services; and is certified by Medicare. The term "skilled nursing facility" does NOT include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in activities of daily living.

SPECIALTY CARE PHYSICIAN - A physician who provides certain specialty medical care (Optional depending on plan practices: upon referral by a PCP.) Plans must disclose procedures for seeking specialty care.

URGENTLY-NEEDED CARE - Covered services that are provided outside (Health Plan Name's) service area by non-plan physicians or facilities. They are covered services that are required in order to prevent serious deterioration of your health resulting from an unforeseen illness or injury if: (a) you are temporarily absent from (Health Plan Name's) service area; and (b) receipt of the health care services cannot be delayed until you return to the service area.

VISITORS PROGRAM - A Medicare managed care policy which allows Medicare beneficiaries enrolled in risk organizations (and with some special caveats, cost organizations) to receive non-emergent/urgent services from affiliated health care providers while out of the service area of the contracting organization in which they are enrolled (the home organization). For full details see HCFA/OMC Operational Policy Letter 96.042.

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1 If applicable.

SECTION 2
ELIGIBILITY, ENROLLMENT, AND EFFECTIVE DATE

ELIGIBILITY FOR MEMBERSHIP IN (HEALTH PLAN NAME)

To be eligible to enroll as a member of (Health Plan Name), you must meet all of the following requirements:

You must:

1. Live in (Health Plan Name)'s Medicare service area.

   Medicare beneficiaries living in the following counties and zip codes in the United States may enroll in (Health Plan Name).

   Counties:

   Zip Codes:

2. Be enrolled in Supplementary Medical Insurance (Medicare Part B). **NOTE TO PLAN**: If the member does not have Part A coverage, please insert information on or in your Part B package. You should also insert information about options for obtaining Part A services.

3. Not have elected coverage from a Medicare-certified hospice prior to the effective date of enrollment[1]; and

4. Not currently have End Stage Renal Disease (ESRD) (that is, permanent kidney failure which requires regular kidney dialysis or a transplant to maintain life)[2] or had a kidney transplant in the past 36 months. (This does not apply if you are currently a non-Medicare member of (Health Plan Name).)

IF YOU MEET THE ABOVE CONDITIONS, YOU CANNOT BE DENIED MEMBERSHIP IN (HEALTH PLAN NAME).

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1 You may not enroll in (Health Plan Name) if you have elected hospice coverage or if you have End Stage Renal Disease. However, after you become a member of (Health Plan Name), you may elect to receive hospice benefits from a hospice certified by Medicare. If you elect hospice care, the hospice will be responsible for most of your care rather than (Health Plan Name). If you develop ESRD while you are a member of (Health Plan Name), you cannot be forced to disenroll from (Health Plan Name).

ENROLLMENT

If you are eligible, you may submit a completed enrollment application form to the health plan at any time during an open enrollment period. Contact (Health Plan Name) to obtain information about when it will be open for enrollment. **NOTE TO PLAN:** Health plan should include enrollment specifics here.) An application must be complete (including your signature) in order to be processed. It will be processed in the order received. **NOTE TO BENEFICIARY:** If you are already a member of another health maintenance organization with a Medicare contract, membership in that organization will automatically be ended on the effective date of your enrollment in (Health Plan Name).

EFFECTIVE DATE

Your effective date of enrollment in (Health Plan Name) is the date indicated on the letter we will send you to confirm your enrollment in (Health Plan Name). From that date forward, you must receive all health care from (Health Plan Name) providers (Optional depending upon Plan: your (Health Plan Name) primary care physician), except for emergencies, urgently-needed care outside the service area, or care arranged by (Health Plan Name), such as referrals to a specialist or to a non-plan physician.

(For contractors with a POS benefit feature or Visitors Program: List plan specific requirements and level of coverage found in your EOC.)

(For "Cost" Contractors: After your enrollment is effective, in order for (Health Plan Name) to fully pay for medical services for you, these services (except for emergency and out-of-area urgently-needed services) must be provided or arranged by (Health Plan Name). You may receive services that are not provided or arranged by (Health Plan Name), but you will be responsible for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare Program. You may be liable for any charges not covered by the Medicare Program.) **NOTE TO PLAN:** Be sure to offer adequate explanation of Medicare card use with out-of-plan utilization which is not an emergency or urgently-needed service.

There are three exceptions to this rule:

1. Emergency Care

Emergencies are those situations when you need medical care immediately because of a sudden illness (or worsened illness) or injury; and, the time needed to reach (Health Plan Name) doctors or hospitals could **APPEAR TO YOU** to mean a risk of permanent damage to your health. In an emergency, it does not matter if you are inside or outside of the area where your plan provides its medical services (known as the plan's service area). You should go to the nearest hospital or other health care provider to seek and receive care. (Health Plan Name) will pay for the out-of-plan emergency care you need. If possible, call or have someone else call your plan as soon as

you can when receiving your emergency care.

Your health plan will pay for out-of-plan emergency care. There may be occasions, however, when your plan will refuse to pay for this care if the plan does not agree it was an emergency. Should your plan deny payment, you have a right to appeal the plan's decision to HCFA.

2. Out-of-Area Urgently Needed Care

(Health Plan Name) will pay for your care if you have an unexpected illness or injury while you are temporarily outside of the plan's service area. This urgently needed care coverage is only available to you if:

- the care you receive is unexpected (you could not know that you would need this care);
- you are temporarily outside of the service area;
- your illness or injury requires medical attention to prevent a serious worsening of your health; and
- you cannot delay necessary medical attention until you return to the service area.

As soon as possible, call (Health Plan Name) when you receive out-of-area urgently needed care.

Remember, if you require urgently-needed medical care while you are within (inside of your health plan's service area), you must get your care through your plan. Again, you should contact your plan or your doctor inside your plan's service area for instructions on what to do in these types of situations.

3. Point of Service Benefit

Some plans allow Medicare beneficiaries to go to doctors and hospitals that are not a part of the plan's health care delivery system. This option can also be considered an out-of-plan benefit. In most cases, beneficiaries will have to pay more for the out-of-plan benefits. Please read the materials (Health Plan Name) sent you as a member to find out if this plan offers its members an out-of-plan option. If it does, learn exactly what these benefits are and their specific restrictions.

Remember, if your plan offers you this option, you will receive rules on out-of-plan use, which if not followed could lead to the plan refusing to pay for your care. Should this occur, you have a right to appeal its decision to HCFA. These rules will be in the material the plan sent you. If you are not clear about what these rules say, call your plan's Member Services Department for clarification.

4. Visitors Program Benefit - Affiliate option

Some plans allow Medicare beneficiaries to remain enrolled in the plan during an extended absence from the service area and receive the full scope of services from a participating affiliate organization or permit them to receive services while a visitor in another part of the country.

The Visitor Program, as it may be called, may be used as a travel benefit as well as a snowbird benefit. The beneficiary remains an enrolled member of the home plan. **NOTE TO PLAN:** If your plan has an approved Visitor (or affiliate) Program, describe the operations and rules of this program here and reference any other member materials that describe it more fully. If your health plan offers a "worldwide emergency care" benefit, information on this benefit should replace the preceding United States, Mexico, and Canada limitation statement.

SECTION 3
YOUR FINANCIAL LIABILITY AS A (HEALTH PLAN NAME) MEMBER

As a member of (Health Plan Name), you have the following financial obligations:

HEALTH PLAN PREMIUM - (Not applicable to zero premium plans). **NOTE TO PLAN**: Since there is so much variation on premium payment from plan to plan, e.g. payment monthly versus quarterly; whether there is a grace period allowed versus none allowed; when payment is due; types of notices sent, etc., HCFA has no sample language for the first part of this section. However the following information should be included in your document.

YOUR FAILURE TO MAKE (HEALTH PLAN NAME) PREMIUM PAYMENTS WILL NOT IMMEDIATELY RETURN YOU TO FEE-FOR-SERVICE MEDICARE AND WILL NOT CAUSE AN AUTOMATIC DISENROLLMENT FROM THIS HEALTH PLAN. You must be aware, however, that if you continually fail to pay the health plan premiums, and the health plan can demonstrate that it has made a reasonable effort to collect the unpaid premiums, the health plan is permitted to disenroll you.

UNTIL YOU ARE NOTIFIED OF YOUR DISENROLLMENT, YOU ARE STILL A MEMBER OF THIS HEALTH PLAN AND MUST CONTINUE TO USE PLAN PROVIDERS EXCEPT IN EMERGENCIES OR OUT-OF-AREA URGENT CARE.

(For contractors with a POS benefit feature or Visitors Program: List plan specific requirements and level of coverage found in your Evidence of Coverage.)

(For "Cost" Contractors: After your enrollment is effective, in order for (Health Plan Name) to fully pay for medical services for you, these services (except for emergency and out-of-area urgently-needed services) must be provided or arranged by (Health Plan Name). You may receive services that are not provided or arranged by (Health Plan Name), but you will be responsible for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare Program. You may be liable for any charges not covered by the Medicare Program.) **NOTE TO PLAN:** Be sure to offer adequate explanation of Medicare card use with out-of-plan utilization which is not an emergency or urgently-needed service.

IF YOU RECEIVE UNAUTHORIZED OUT-OF-PLAN SERVICES, NEITHER (HEALTH PLAN NAME) NOR MEDICARE WILL PAY FOR THOSE SERVICES.

(Health Plan Name) has the right to disenroll you for failure to pay health plan premiums (except premiums which cover optional services[1] and for failure to pay copayments. However, prior to

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1 Nonpayment of plan premiums for optional benefits will result in discontinuation of those benefits, but not termination of your enrollment.

such action, (Health Plan Name) will: (a) contact you regarding the payment due; and (b) give you written notice of disenrollment, including an explanation of your right to a hearing under (Health Plan Name)'s grievance procedures.

All co-payments specified in the Medical Services and Hospital Services sections of this agreement must be paid in addition to the plan premium.

(Optional with Plan: **Co-payment** shall be paid to the physician or provider at the time of service).

(Explain **coinsurance**, if any.)

(Explain **deductible,** if any.)

(Explain any **POS** option.)

CHANGES IN (HEALTH PLAN NAME)'S PREMIUMS - Increases in premiums and/or decreases in the level of coverage are only permitted at the beginning of each contract year (which is usually the calendar year) and must be approved by HCFA. You will receive written notice at least 30 days prior to the date when such change shall become effective.

MEDICARE PART B PREMIUM - As a (Health Plan Name) member, you must continue to pay your Medicare Part B premium. If you receive a Social Security Administration or Railroad Retirement Board annuity check, this premium is automatically deducted from your check. Otherwise your premium is paid directly to Medicare by you or someone on your behalf (such as your State Medicaid Agency).

SECTION 4
PHYSICIAN AND OTHER MEDICAL SERVICES

Medical services are available only when provided or arranged by a plan physician or by (Health Plan Name) except for (1) urgently-needed care when you are temporarily outside of the geographic service area or (2) emergency services anywhere in the United States and in certain Mexican or Canadian hospitals. **(NOTE TO PLAN:** If your health plan offers a "world-wide emergency care" benefit, information on this benefit should replace the preceding United States, Mexico, and Canada limitation statement), or (3) when approved in advance by the health plan. Medical services provided by specialty care physicians must be approved in advance by (Health Plan Name) (varies with plan: your primary care physician).

Services that are not authorized in advance from (Health Plan Name optional, varying by plan: your primary care physician) will result in your obligation to pay for these services. NEITHER (HEALTH PLAN NAME) NOR MEDICARE WILL PAY FOR THESE SERVICES. MOST SUPPLEMENTAL INSURANCE ALSO WILL NOT PAY EITHER. **NOTE TO PLAN**: You may not make the member responsible for obtaining or verifying the prior approval or authorization of services.) (Alternate language for cost contracts: services provided by a speciality care physician or non-plan physician without approval in advance from (Health Plan Name) (optional, varying by plan: your PCP will be covered by Medicare not by (Health Plan Name). You will be required to pay Medicare coinsurance and deductibles and any amount Medicare does not pay up to the Medicare Limiting Charge.

Subject to the terms of this agreement, the following medical services shall be provided and paid for by (Health Plan Name) when reasonable and medically necessary for the diagnosis or treatment of an illness or injury. (Health Plan Name) covers all of the Medicare covered services that are available to Medicare beneficiaries not enrolled in a health plan (Varies with plan: plus certain other services not covered by Medicare.)

NOTE TO PLAN: If more than one type of practitioner or provider is qualified to perform a service, you have the option of choosing which practitioner or provider (as allowed by State law) you use to furnish a specific service as long as all Medicare covered services are available and accessible and services are of high quality. The beneficiary is entitled to the same benefits that he/she would receive in fee-for-service Medicare. List additional benefits beyond the Medicare covered benefits listed below; include copayments and lifetime limits, if applicable.

- physicians' services
- services and supplies incident to a physician's professional services
- physician assistant services
- nurse practitioner services
- clinical nurse specialist services
- certified nurse-midwife services
- clinical psychologist services

- clinical social worker services
- certified registered nurse anesthetist services
- outpatient physical therapy services, including independent therapists
- outpatient occupational therapy services, including by independent therapists
- outpatient speech-language pathology services
- dialysis supplies, equipment, and services
- antigens
- blood clotting factors
- immunosuppressive drugs
- osteoporosis drugs
- Erythropoietin (EPO) for dialysis patients
- oral anticancer drugs
- pneumococcal vaccine
- influenza vaccine
- hepatitis B vaccine
- diagnostic x-ray tests
- diagnostic lab tests
- other diagnostic tests
- radiotherapy
- surgical dressings
- splints, casts, etc.
- durable medical equipment
- prosthetic devices
- braces (orthotics)
- artificial legs, arms, & eyes (prosthetics)
- shoes for diabetics
- screening mammography
- screening pap smear
- ambulance service
- outpatient hospital services
- outpatient RPCH services
- home health services
- rural health clinic services
- federally qualified health center services
- Certified Outpatient Rehabilitation Facility services
- Ambulatory Surgical Center facility services
- partial hospitalization services provided by a CMHC
- hospice services if provided by Medicare-certified hospice

For a complete listing of Medicare covered services, please call your local Social Security Office or the Medicare Hotline number at 1-800-638-6833, or TTY 1-800-820-1202.

RIGHTS TO APPEAL

If (Health Plan Name) has denied payment for services you believe should have been covered, or if (Health Plan Name) refuses to provide or arrange for services that you believe are covered by Medicare, you have the right to appeal. See SECTION 11, Grievance and Appeal Procedures.

SECTION 5
HOSPITAL SERVICES

Hospital services shall be covered except for (1) urgently needed care outside of the service area, or (2) in an emergency anywhere in the United States and in certain Mexican or Canadian hospitals. **NOTE TO PLAN:** If your health plan offers a "world-wide emergency care" benefit, information on this benefit should replace the preceding United States, Mexico, and Canada limitation statement), or (3) when approved by the health plan. Otherwise, services are available ONLY IN A PLAN HOSPITAL AND ONLY WHEN AUTHORIZED OR PROVIDED BY A PLAN PHYSICIAN.

Hospital services for medically necessary care shall be provided until discharge, as follows:

NOTE TO PLAN: List additional benefits beyond the Medicare covered benefits listed below and include co-payments, if applicable.

- inpatient hospital services
- inpatient rural primary care hospital services
- SNF-post-hospital extended care services
- home health services
- hospice care - provide procedures for referring members for hospice care

For a complete listing of Medicare covered services, please call your local Social Security Administration Office or the Medicare Hotline number at 1-800-638-6833, or TTY 1-800-820-1202.

RIGHTS TO APPEAL

If (Health Plan Name) has denied payment for services you believe should have been covered, or if (Health Plan Name) refuses to provide or arrange for services that you believe are covered by Medicare, you have the right to appeal. See SECTION 11, Grievance and Appeal Procedures.

NOTE TO BENEFICIARY: For beneficiaries with Part B coverage only, this section on hospital services may not apply.

SECTION 6
EMERGENCY AND OUT-OF-AREA URGENTLY-NEEDED CARE

EMERGENCIES

In the event of an emergency, go to the closest emergency room or to the nearest health plan hospital (if applicable: or call 911 for assistance). (Health Plan Name) will cover services provided in an emergency whether you are in or out of the HMO's service area. (This is limited to the United States and certain Mexican or Canadian hospitals). **NOTE TO BENEFICIARY**: If your Health plan offers a "world-wide emergency care" benefit, information on this benefit should replace the preceding United States, Mexico, and Canada limitation statement. You should have someone telephone (Health Plan Name) at (Health Plan Phone Number) as soon as possible. You do not, however, have to receive prior approval from the plan in order to be covered for emergency care received outside of the plan. The health plan is required to pay for medically necessary emergency services which you receive from non-plan providers.

Emergency services means covered inpatient or outpatient services that are furnished by an appropriate source other than the health plan that meet the following conditions:

(1) Are needed immediately because of an injury or sudden illness.
(2) Are such that the time required to reach the health plan's providers or suppliers (or alternatives authorized by the health plan) would mean risk of permanent damage to the enrollee's health.

Once initiated, the services continue to be considered emergency services as long as transfer of the enrollee to the health plan source of health care or authorized alternative is precluded because of risk to the enrollee's health or because transfer would be unreasonable given the distance and the nature of the medical condition. When the emergency situation is over, it is important to notify (Health Plan Name) so we can be involved in the management of your health care and transfer to (Health Plan Name) facilities can be arranged when your medical condition is stable (depending on the distance involved). Please contact (Health Plan Name) within 48 hours of the emergency or as soon as possible.

If you have an emergency or urgently-needed care situation while out of the (Health Plan Name)'s service area, we prefer that you return to the service area after your medical condition has stabilized and receive follow-up care through your (Health Plan Name) physician. However, medical care will be covered out-of-area as long as the care required continues to meet the definition for either emergency or urgently-needed care.

If you have an emergency within (Health Plan Name)'s service area, you must receive any follow-up care after your medical condition has stabilized through (Health Plan Name).

OUT-OF-AREA URGENTLY-NEEDED CARE

(Health Plan Name) will also cover urgently-needed services.

> **Urgently-Needed services** means covered services that are needed by an enrollee who is temporarily absent from (Health Plan Name)'s service area, and that:
>
> (1) Are required in order to prevent serious deterioration of the enrollee's health as a result of unforseen injury or illness; and
>
> (2) Cannot be delayed until the enrollee returns to the (Health Plan Name's) service area.

If such a medical need arises, the health plan requests that you, if possible, first telephone (Health Plan Name), and then seek care from an appropriate local medical facility.

When an urgent situation is over, it is important to notify (Health Plan Name) so we can be involved in the management of your health care and transfer to (Health Plan Name) facilities can be arranged when your medical condition is stable (depending on the distance involved). Please contact (Health Plan Name) within 48 hours of receiving urgent care or as soon as possible.

While (Health Plan Name) prefers that you return to the service area and receive follow-up care through your (Health Plan Name) physician, follow-up care will be covered out of area when the care required continues to meet the above definition of urgently-needed care.

ROUTINE OR ELECTIVE MEDICAL SERVICES NOT AUTHORIZED BY (HEALTH PLAN NAME) WHICH ARE PROVIDED BY NON-PLAN PHYSICIANS OR PROVIDERS ARE NOT COVERED SERVICES AND NEITHER (HEALTH PLAN NAME) NOR MEDICARE WILL PAY FOR SUCH SERVICES. MOST SUPPLEMENTAL INSURANCE POLICIES ALSO WILL NOT PAY.

(For contractors with a POS benefit feature or Visitors Program: List plan specific requirements and level of coverage found in your Evidence of Coverage.)

(For "Cost" Contractors: After your enrollment is effective, in order for (Health Plan Name) to fully pay for medical services for you, these services (except for emergency and out-of-area urgently-needed services) must be provided or arranged by (Health Plan Name). You may receive services that are not provided or arranged by (Health Plan Name), but you will be responsible for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare Program. You may be liable for any charges not covered by the Medicare Program.) **NOTE TO PLAN:** Be sure to offer adequate explanation of Medicare card use with out-of-plan utilization which is an emergency or urgently-needed service.

REFUNDS FOR EMERGENCY OR URGENTLY-NEEDED CARE PAID BY MEMBER

If you paid for any emergency or out-of-area urgently-needed care services obtained from non-plan providers, you should submit your bills to the health plan for a payment determination (Please explain the circumstances of the situation when submitting a bill.) The bill should be submitted to the following address: _____
_____. If you have questions about any bills, contact the Member Services Department at (Health Plan Phone Number).

Please note that you must submit your bills within the following timeframes or as quickly as possible.

For services received between:	The claim must be filed by:
October 1, 1996 & September 30, 1997	December 31, 1998
October 1, 1997 & September 30, 1998	December 31, 1999
October 1, 1998 & September 30, 1999	December 31, 2000

NOTE TO PLANS: Health plans may not be more restrictive than these above timeframes. Please modify if your plan's limits are less restrictive.

RIGHTS TO APPEAL

If (Health Plan Name) has denied payment for services you believe should have been covered, or if (Health Plan Name) refuses to provide or arrange for services that you believe are covered by Medicare, you have the right to appeal. See SECTION 11, Grievance and Appeal Procedures.

SECTION 7
SERVICES NOT COVERED

ANY SERVICES NOT PROVIDED OR ARRANGED BY A PLAN PHYSICIAN OR APPROVED IN ADVANCE BY THE HEALTH PLAN (EXCEPT FOR URGENTLY NEEDED CARE OUTSIDE OF THE SERVICE AREA OR FOR AN EMERGENCY ANYWHERE IN THE UNITED STATES AND CERTAIN MEXICAN OR CANADIAN HOSPITALS) ARE NOT COVERED BY THE HEALTH PLAN NOR BY MEDICARE.

(For contractors with a POS benefit feature or Visitors Program: List plan specific requirements and level of coverage found in your Evidence of Coverage.)

(For "Cost" Contractors: After your enrollment is effective, in order for (Health Plan Name) to fully pay for medical services for you, these services (except for emergency and out-of-area urgently-needed services) must be provided or arranged by (Health Plan Name). You may receive services that are not provided or arranged by (Health Plan Name), but you will be responsible for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare Program. You may be liable for any charges not covered by the Medicare Program.) **NOTE TO PLAN:** Be sure to offer adequate explanation of Medicare card use with out-of-plan utilization which is not an emergency or urgently-needed service.

NOTE TO PLAN: This alphabetical list shows most of the major services and supplies not usually paid for by Medicare. However, some of these items can be covered by Medicare under certain conditions; such "special condition" items are marked with an asterisk. Some benefits may be covered as additional or supplemental benefits under your plan. You should remove these from the list.

- Acupuncture
- Chiropractic services except for manual manipulation for subluxation of the spine when demonstrated by x-rays
- Christian Science practitioner's services
- Cosmetic surgery, unless it is needed because of prompt repair of accidental injury or to improve the function of a malformed part of the body. Breast reconstruction is not considered cosmetic and is covered.
- Custodial care (**NOTE TO PLAN:** There is a lot of misunderstanding in this area. Marketing materials must clearly explain what is not covered because it is primarily custodial. See SECTION 1, Definitions).

- Dental care, except surgery of the jaw or related structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a medical doctor

- Outpatient drugs and medicines you buy and administer yourself with or without a doctor's prescription

- Eyeglasses and eye examinations for prescribing, fitting, or changing eyeglasses or contact lenses, except when needed as the result of cataract surgery

- Routine foot care, unless associated with disease affecting the lower limbs, such as severe diabetes, which requires care of a podiatrist or a physician

- Hearing aids and hearing examinations for prescribing, fitting, or changing hearing aids

- Homemaker services*

- Hospice services in a Medicare-participating hospice are not covered under (Health Plan Name) but are covered under Medicare when you enroll in a Medicare-certified hospice. (Health Plan Name) will refer you to a Medicare-participating hospice if you wish to elect such coverage. You may remain enrolled in (Health Plan Name) even though you have elected hospice coverage. You may continue to receive care unrelated to the terminal condition through (Health Plan Name) and you may also use a (Health Plan Name) doctor as your hospice attending physician.

- Immunization, except for pneumococcal vaccinations, immunizations required because of an injury or immediate risk of infection, hepatitis B vaccine for certain persons at risk, and flu shots

- Injections which can be self-administered, such as insulin

- Meals delivered to your home

- Naturopaths' services

- Nursing care on a full-time basis in your home

- Orthopedic shoes, except for therapeutic shoes for those suffering from severe diabetic foot disease, or unless they are part of a leg brace and are included in the orthopedist's charge

- Personal convenience items, such as a telephone or television in your room at a hospital or nursing facility
- Physical examinations that are routine (for example, yearly physical examinations that are not to treat an illness or injury) and tests directly related to such examinations
- Private duty nurses
- Experimental procedures and items
- Services performed by immediate relatives or members of your household
- Services provided outside the United States and its territories*
- Services which are not reasonable and necessary under Medicare program standards
- Supportive devices for the feet, except for orthopedic or therapeutic shoes (see above limitations for orthopedic shoes)

Please call our member services department, Monday through Friday, (Hours of Operation) at (Health Plan Name Phone Number) if you have any questions or need more information about services that are not covered.

SECTION 8
COORDINATION OF BENEFITS

COORDINATION OF BENEFITS (COB) - WHO PAYS FIRST?

(Health Plan Name) is always the secondary payer in cases involving worker's compensation insurance, liability auto insurance, and most employer group health programs (in the case of employed Medicare members and their spouses; employed members and certain members of the family of employed individuals with ESRD during a period of up to 18 months; and for certain disabled individuals with employer group coverage). (Health Plan Name) will use the same guide as Medicare.

Because of this, we may ask you for information about other insurance you may have. If you have other insurance, you can help us obtain payment from the other insurance by providing the information we request promptly.

COB ensures that the proper insurers are held responsible for the costs of your health care and is one of the factors that can help hold down the premiums you pay to the health plan.

SECTION 9
CONFIDENTIALITY AND RELEASE OF INFORMATION

Information from your medical records and such information from physicians or hospitals shall be kept confidential in accordance with federal and state law. Except as is necessary in connection with administering the Medicare contract and fulfilling State and Federal requirements (including review programs to achieve quality and cost-effective medical care), such information will not be disclosed without your written consent.

SECTION 10
TERMINATION OF COVERAGE
GENERAL PROVISIONS

MOVES OR EXTENDED ABSENCE FROM THE SERVICE AREA

If you are permanently moving out of the health plan's service area or plan an extended absence, (that is, if you expect to be absent from the service area for more than 90 consecutive days) you must disenroll from the health plan prior to the move. (Plans with affiliate relationships must provide approved language to nullify this statement.)

Failure to notify the health plan of a permanent move or extended absence may result in your having to pay for services obtained out of the service area. That is, if you leave the service area for more than 90 consecutive days and do not notify the plan and if you do not disenroll, you are still required to receive all health services (except for emergencies and urgently-needed services) from (Health Plan Name) (Optional, depending on plan practices: your _____ _____ primary care physician). Neither Medicare nor (Health Plan Name) will pay for services received from non-plan providers.

VOLUNTARY DISENROLLMENT

You may choose to end your membership in (Health Plan Name) at any time and for any reason. You may disenroll by giving written notification to the health plan of your desire to disenroll. When you disenroll you will be provided a copy of your written request for disenrollment. You may also disenroll through any Social Security Administration Office or Railroad Retirement Board Office, and/or by joining another health plan. **NOTE TO PLAN**: HCFA recommends that you have a disenrollment form. Please refer to the Model Disenrollment Form B-1 in Chapter 5.

Disenrollment from the health plan will be effective on the first day of the month following the month (Health Plan Name), the Social Security Administration or Railroad Retirement Board receives the written request (unless a later date of disenrollment is requested).

Even though you have requested disenrollment you must continue to receive all covered medical services except for emergency and out-of-area urgent care, from providers of the health plan until the effective date of disenrollment.

If you elect to disenroll from (Health Plan Name) prior to the effective date of your enrollment into the health maintenance organization, you will have remained in the fee-for-service Medicare program. Under such circumstances, your enrollment will not have become effective and (Health Plan Name) will not provide or be responsible for health care you receive during this period. You are covered under the Fee-for-service Medicare program during this period.

(For contractors with a POS benefit feature or Visitors Program: List plan specific requirements and level of coverage found in your Evidence of Coverage.)

(For "Cost" Contractors: After your enrollment is effective, in order for (Health Plan Name) to fully pay for medical services for you, these services (except for emergency and out-of-area urgently-needed services) must be provided or arranged by (Health Plan Name). You may receive services that are not provided or arranged by (Health Plan Name), but you will be responsible for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare Program. You may be liable for any charges not covered by the Medicare Program.) **NOTE TO PLAN:** Be sure to offer adequate explanation of Medicare card use with out-of-plan utilization which is not an emergency or urgently-needed service. When you disenroll from (Health Plan Name); fee-for-service Medicare coverage will begin the day your (Health Plan Name) enrollment ends.

INVOLUNTARY DISENROLLMENT

You may only be involuntarily disenrolled by (Health Plan Name) for only the following reasons:

(1) You move permanently out of the health plan's service area and do not voluntarily disenroll;

(2) If you are outside the service area for more than 90 consecutive days and the health maintenance organization does not have a Visitors Program or general retention option. **NOTE TO PLAN:** List plan specific requirements;

(3) Your entitlement to Part B Medicare benefits ends[1];

(4) You supply fraudulent information or misrepresentation on the membership application form which materially affects your eligibility to enroll in the health plan[2];

[1] Disenrollment as result of 3 above is subject to the (Health Plan Name) Grievance Procedures.

[2] Abuse as a result of 4 above requires health plan's referral to the Inspector General, and may result in criminal prosecution.

(5) Your behavior is disruptive, unruly, abusive, or uncooperative to the extent that (Health Plan Name's) ability to provide services is impaired. Involuntary disenrollment on this basis is subject to approval by HCFA[1];

(6) You knowingly permit abuse or misuse of the (Health Plan Name) membership card[2];

(7) You fail to make any required premium payment to cover your Medicare deductibles and coinsurances or other required payments. After making a reasonable effort to collect the premium due, (Health Plan Name) will notify you prior to the effective date or disenrollment. If you do not pay optional premiums or charges for non-Medicare benefits, we will discontinue those benefits, but you will remain enrolled in (Health Plan Name).

(8) The contract between (Health Plan Name) and HCFA is terminated.

UNTIL YOU ARE NOTIFIED IN WRITING OF A DISENROLLMENT, YOU ARE A MEMBER OF THIS HEALTH PLAN AND MUST CONTINUE TO RECEIVE YOUR MEDICAL CARE FROM (HEALTH PLAN NAME) PROVIDERS. NEITHER (HEALTH PLAN NAME) NOR MEDICARE WILL PAY FOR SERVICES RECEIVED FROM NON-PLAN PROVIDERS, EXCEPT FOR URGENTLY-NEEDED CARE OUTSIDE OF THE SERVICE AREA, EMERGENCIES ANYWHERE IN THE UNITED STATES AND THOSE TREATED IN CERTAIN MEXICAN OR CANADIAN HOSPITALS (ALTERNATE LANGUAGE: ANYWHERE IN THE WORLD) AND REFERRALS MADE BY _____ (DIFFERS FROM HEALTH PLAN NAME).

(For contractors with a POS benefit feature or Visitors Program: List plan specific requirements and level of coverage found in your Evidence of Coverage.)

(For "Cost" Contractors: After your enrollment is effective, in order for (Health Plan Name) to fully pay for medical services for you, these services (except for emergency and out-of-area urgently-needed services) must be provided or arranged by (Health Plan Name). You may receive services that are not provided or arranged by (Health Plan Name), but you will be responsible for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare Program. You may be liable for any charges not covered by the

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1 Disenrollment as a result of 5 above is subject to the (Health Plan Name) Grievance Procedures.

2 Abuse as a result of 6 above requires health plan's referral to the Inspector General, and may result in criminal prosecution.

Medicare Program.) **NOTE TO PLAN:** Be sure to offer adequate explanation of Medicare card use with out-of-plan utilization which is an emergency or urgently-needed service.

SECTION 11
GRIEVANCE AND APPEAL PROCEDURES

NOTE TO PLAN: Federally-qualified HMOs and CMPs are required by statute and regulation to have internal grievance procedures. In addition, Medicare Managed Care Organizations (MCO) are required to follow the Medicare Appeals Procedures of 42 CFR 417.600. These procedures must be clearly explained in the EOC document, including the differences between the two processes and step-by-step instructions on how to file grievances and Medicare appeals.

The MCO internal grievance procedures apply only when the Medicare appeals procedures do not. However, a beneficiary complaint may contain both a grievance and a request for service (or reconsideration). In these instances, each component of the complaint should be directed to the appropriate procedure.

Medicare appeals procedures are also applicable to all benefits covered in the basic benefit package. The appeal procedures do not apply to optional supplemental benefits.

GRIEVANCE PROCEDURES

1. As a member of (Health Plan Name), you have the right to file a complaint--also called a grievance--about problems you observe or experience with the health plan. The types of situations in which you can file a grievance include:

   - Complaints about services in an optional supplemental benefit package;
   - Complaints regarding such issues as waiting times, physician behavior and demeanor, adequacy of facilities, and other similar member concerns;
   - Involuntary disenrollment situations (disenrollment for cause requires prior HCFA approval).
   - Complaints concerning the quality of services a member received.

2. To file a complaint, call or write (Health Plan Name)'s Customer/Member Services office at (Health Plan Number). You may ask what the procedures and timeframes are for responding to your complaint. (Health Plan Name) is required to have written procedures, including timeframes, for handling enrollee grievances.

   (Health Plan Name) must submit your complaint to the appropriate decision maker with the health plan and do so in a timely manner.

Appropriate action will be taken promptly, including a full investigation, if necessary. (Health Plan Name) will notify you in writing of the results of their efforts or respond to your complaint or grievance.

APPEALS RIGHTS

As a member of (Health Plan Name), you have the right to appeal any decision about (Health Plan Name)'s failure to provide what you believe are benefits contained in the basic benefit package. These include:

A. Reimbursement for urgently-needed services outside of the service area or emergency services anywhere in the United States and certain Mexican and Canadian hospitals;

B. A denied claim for any other health services furnished by a non-plan provider or supplier that you believe should have been provided, arranged for, or reimbursed by (Health Plan Name);

C. Services you have not received, but which you feel are the responsibility of (Health Plan Name) to pay for or provide;

D. In addition, you may appeal any decision to discharge you from the hospital too early. In this case, a notice will be given to you with information about how to appeal to a Medicare Peer Review Organization. You will remain in the hospital while the Peer Review Organization immediately reviews the decision. You will not be held liable for charges incurred during this period regardless of the outcome of the review.

E. Reduction or termination of services you feel are medically necessary covered services.

(Health Plan Name) has a standard appeals process and an expedited appeals process. The Member Handbook and other health plan documents contain information and instructions for using these procedures. Below is a general explanation of this important protection.

APPEALS PROCEDURES

You can have a friend, lawyer, or someone else help you. There are groups, such as legal aid services, that can help you find a lawyer or give you free legal services if you qualify. There are lawyers who do not charge unless you win your appeal.

The Medicare Standard Appeals Procedure is, as follows:

1. Within 60 days after you ask for a service for payment of emergency or urgently-needed out-of-plan services, (Health Plan Name) must notify you in writing of its decision. If the decision is a denial (partial or complete) the notice must state the reasons for the denial. Also, (Health Plan Name) must inform you of your right to a reconsideration. If you have not received such a notice within 60 days, you may assume the decision is negative and file for a reconsideration. **NOTE TO PLAN:** This does not relieve you from your obligation to inform members of the decision and further appeal rights.

2. To request a reconsideration, you must submit the request in writing to (Health Plan Name, Address of Health Plan and Contact (e.g., member service representative)) or through the Social Security Administration or Railroad Retirement Board Office (if you are a railroad annuitant) within 60 days of the date of the notice of the initial decision from the health plan. (This 60-day limit may be extended for good cause. You may submit additional evidence for review with this request either in person or in writing).

3. A reconsideration decision will be reached by (Health Plan Name) personnel based upon a review of the initial determination and any new evidence available. The reconsideration decision will be made by a person or persons not involved in making the initial determination.

4. If (Health Plan Name) decides to uphold the original decision to deny, either in whole or in part, the entire file will be forwarded by (Health Plan Name) to the Center for Health Dispute Resolution. They will either uphold your health plan's decision or issue a new decision. Under contract to HCFA, the Center for Health Dispute Resolution reviews these health plan decisions.

5. For cases submitted for review, the Center for Health Dispute Resolution will make a reconsideration decision and advise you of the decision and the reasons for the decision. If they decide in favor of the health plan, you will be informed of the right to a hearing before an administrative law judge of the Social Security Administration.

6. You may request a hearing before an administrative law judge by writing to the health plan, HCFA, Social Security Administration or, if you are a qualified Railroad Retirement beneficiary, at a Railroad Retirement Board Office within 60 days after the date of notice that the reconsidered decision was not in your favor. (This 60-day notice may be extended for good cause.) A hearing can be held only if the amount in controversy is $100 or more (as determined by the administrative law judge). All hearing requests will be forwarded to the Center for Health Dispute Resolution. They will forward your request and your reconsideration file to the hearing office.

7. The administrative law judge's adverse decision can be reviewed by the Appeals Council of the Department of Health and Human Services, either by its own action or as the result of a request from you or (Health Plan Name).

8. If the amount involved is $1,000 or more, either you or (Health Plan Name) may request that a decision made by the Appeals Council or administrative law judge be reviewed by a Federal District Court.

9. An initial, revised, or reconsideration determination made by the health plan, the Center for Health Dispute Resolution, the administrative law judge, or the Appeals Council can be reopened (a) within 12 months, or (b) within 4 years, for just cause, or at any time for clerical correction or in cases of fraud.

EXPEDITED DETERMINATIONS AND RECONSIDERATIONS

1) Expedited Determinations. If you believe you need a service or a referral--but your health could be jeopardized by waiting several weeks for a decision--you may request that the decision be expedited. If (Health Plan Name) decides that the time frame for the standard process could seriously jeopardize your life, health, or ability to regain maximum functioning, the review of your request will be expedited. In these cases, the health plan will notify you of its decision within 72 hours of your request. If your request involves a physician who is not part of (Health Plan Name)'s network, the 72-hour time begins after the physician submits necessary information.

2) Expedited Reconsiderations. If you want to appeal a referral or service denial by your doctor or health plan, or appeal a decision to discontinue a service you believe you need--and if your health could be seriously jeopardized by waiting several weeks for the standard reconsideration described above--you may request an expedited appeal. If (Health Plan Name) decides that the time frame for the standard reconsideration process could seriously jeopardize your life, health, or ability to regain Maximum functioning, the appeal will be expedited. In these cases, (Health Plan Name) will notify you of its decision within 72 hours of your request. If your request involves a physician who is not part of (Health Plan Name)'s network, the 72-hour time begins after the physician submits necessary information.

If you disagree with a decision to discharge you from the hospital, see the next section.

3) To request an expedited determination, follow the instructions of (Health Plan Name). Health plans have a telephone number and other processes, such as FAX numbers, for getting these time-sensitive requests.

4) If your doctor requests or supports your request that the process be expedited, then the plan must automatically expedite the review. No further proof of urgency is needed.

5) If (Health Plan Name) decides that your request is not time-sensitive, it will automatically

begin processing your request under standard procedures. If you disagree and believe the review should be expedited, you may file a grievance with the (Health Plan Name).

6) If you or your representative need extra time to provide information to support your case, or if (Health Plan Name) needs additional time (such as to perform additional testing or obtain medical consultation), and extension of up to 10 working days is allowable. (Health Plan Name)'s procedures will explain these time extensions.

HOSPITAL DISCHARGES

When you are first admitted to the hospital, you will receive a booklet entitled "An Important Message from Medicare". Please read this document carefully. It will describe your rights if you believe you are being asked to leave the hospital too soon. If you believe you are being discharged too soon, ask the hospital or (Health Plan Name) for a written notice of explanation immediately, if you have not already received one. This notice is called a Notice of Noncoverage. You must have this if you wish to exercise your right to request a review by a Peer Review Organization. You do not have to pay for your hospital care until the Peer Review Organization makes its decision if you request the review by noon of the first workday after you receive the Notice of Noncoverage.

As a Medicare beneficiary, you have the right to receive all the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. You also have the right to complain about the quality of Medical services provided by (Health Plan Name) not meeting professionally recognized standards of care by writing to the Peer Review Organization. The organization must review the complaint and inform you or your representative of the results of the investigation. They can provide information about its review timeframes and the steps involved in the process.

The Peer Review Organization in your area is: (insert name, address, and telephone number)

If you ask for immediate review by the Peer Review Organization, you will be entitled to this process instead of the regular appeals process. If you choose to utilize your Medicare appeal rights, you would follow the process described above under "Assistance with Appeals".

SECTION 12
ADVANCE DIRECTIVES

NOTE TO PLANS: This section provides general guidance on advance directives. Since the Patient Self-Determination Act requires that plans follow their state laws, no specific language is being proposed.

The Patient Self-Determination Act of 1990 was passed by Congress in 1990 as a part of the Omnibus Budget Reconciliation Act and became law on December 1, 1991. It requires Medicare prepaid health care plans to: (1) provide information at the time of enrollment regarding the state's laws on advance directives and its written policies; (2) document in each patient's medical record whether an advance directive exists; and (3) provide for community and staff education on advance directives.

The Patient Self-Determination Act requires health maintenance organizations to maintain written policies and procedures concerning advance directives and to provide to each enrollee at the time of the initial enrollment the rights of individuals, under the law of the state in which the organization furnishes services, to make decisions regarding medical care. Such information includes the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. 42 CFR 417.436 offers guidance in satisfying this requirement.

Medicare prepaid health plans do not have to provide detailed information regarding advance directives in the Evidence of Coverage if the plan already has a brochure on advance directives. Many states have already prepared a detailed brochure discussing advance directives and how to execute them. The Evidence of Coverage section on advance directives should at a minimum explain what advance directives are and what the plan's policies are; i.e., to whom does the member give the advance directive (to the plan, to their PCP, etc.). The Evidence of coverage can also inform the member how to obtain more detailed information.

SECTION 13
PHYSICIAN INCENTIVE PLAN DISCLOSURE

NOTE TO BENEFICIARY: You are entitled to ask if we have special financial arrangements with our physicians that can affect the use of referrals and other services that you might need. To get this information, call our Member Services Department at (Health Plan Phone Number) and request information about our physician payment arrangements. We will send this information to you within 30 days.

Managed care organizations are required to provide information on the incentive arrangements affecting the organization's physicians to any person receiving Medicare or Medicaid benefits (beneficiary) who requests the information. Therefore, managed care organizations must make the following pieces of information available, upon request, to current, previous, and prospective enrollees:

1. Whether the managed care organizations contracts or subcontracts include physician incentive plans that affect the use of referral services.
2. Information on the type of arrangements used.
3. Whether stop-loss protection is provided for physicians or physician groups.
4. If the managed care organizations is required by the regulation to conduct a customer satisfaction survey, a summary of the survey results.

COMPLETENESS CHECK SHEET FOR MEMBERSHIP RULES MEDICARE CONTRACTING HMOS AND CMPS

Please list the document and page numbers where descriptions can be found about your plan regarding the following required information:

Required information	Document and Page(s)
1. Eligibility for membership including the fact there is no health screening except for hospice and ESRD	_____
2. How and where to enroll as well as how the enrollment is processed (how long it will take, the effective date, and what happens if the enrollment is not accepted by HCFA)	_____
3. How and where to obtain routine services, referral/specialty care and emergency services	_____
4. List of services covered and list of exclusions	_____
5. Lock-in	_____
6. Coverage and definition of emergency and out-of area urgently-needed care as well as procedures for filing claims for such services	_____
7. Beneficiary liability for plan premiums and co-payments and any other liabilities, if any (include information that beneficiaries must continue to pay their Medicare Part B premiums and that the premium and benefit package may change at the beginning of each contract period, but may not change during the contract period unless the change is to the advantage of the member)	_____
8. Advance directives	_____
9A. Disenrollment procedures - both voluntary and involuntary	_____

9B. Information that either the plan or HCFA may terminate or refuse to renew the contract and that the member may disenroll at a local Social Security Administration Office or Railroad Retirement Board Office _____

10. Coordination of benefits _____

11. Moves and extended absences (including the plan's policies concerning retention of members who leave the service area for more than 90 days) _____

12A. Grievance procedures _____

12B. Appeals procedures _____

_____ _____

Signature of Plan Representative Date

CHAPTER VII

MODEL PROVIDER

TERMINATION NOTICE

INTRODUCTION

Health plans are required to notify in writing those beneficiaries using providers who terminate affiliation with the health plan at least 30 days before the affiliation ends. This terminates affiliation with the plan. Such notice must be submitted to HCFA for prior approval. Health planss should seek approval of a standard provider termination letter in advance of any termination situation. Immediate notification may apply when cause for termination occurs.

In order to help transition beneficiaries and reduce the number of voluntary terminations that occur during the provider termination process, plans should conduct follow-up calls to all beneficiaries who do not respond to the provider termination notice and are automatically transferred by the plan to a new facility. **NOTE TO PLAN:** The plan is required to notify a beneficiary in writing if such transfer occurs.

Please remember that the plan losing the provider mails the notice to the affected beneficiaries. Thus, if a provider will no longer be under contract with a plan as of December 1, the plan must send the notice by November 1.

MODEL PROVIDER TERMINATION LETTER

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

(Medical Group Name) has been your (Health Plan Name) primary health care provider.

Effective (Date of Termination), our contract with (Medical Group Name) will expire. You will need to select one of the two following options for your health care needs.

1. If you wish to remain with (Health Plan Name), you will need to contact our Member Services Department at (Health Plan Phone Number) to select another primary health care provider (doctor). We can help you select a physician who is located near your home if you like. Failure to contact (Health Plan Name) WILL NOT result in automatic disenrollment; However, to access health care services you will need to select a new primary health care provider.

2. If your primary care provider continues to practice and you wish to continue your relationship at (Medical Group Name), you will have to disenroll from (drop your membership in) (Health Plan Name) and return to fee-for-service Medicare. To do so, please submit a written disenrollment request to (Health Plan Name), your local Social Security Administration Office, or your Railroad Retirement Board Office (if you are a railroad annuitant). Unless you have requested a later date, disenrollment is effective the first day of the month after the month in which your request is received by (Health Plan Name), Social Security Administration Office, or your Railroad Retirement Board Office.

Your health care needs are our primary concern. We appreciate the opportunity to serve you and look forward to a long and satisfying relationship.

Sincerely,

Plan Representative

ALTERNATIVE MODEL PROVIDER TERMINATION LETTER

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

Thank you for your continued membership in (Health Plan Name). Effective (Date), (Terminated Provider) will no longer be participating as a provider in (Health Plan Name). Consequently, we have arranged for your medical care to be provided by a new primary care physician's office convenient to your home. Of course, if you wish to select another medical office, please refer to your provider directory, or if you have any questions or concerns, call our Customer Service Department at (Health Plan Phone Number).

The new primary care physician's office is (Physician's Office Address). The primary care physicians (Physician Names) are looking forward to continuing your care at their office. You need not take any action to make this change of providers, since your membership will be transferred automatically. Your medical records will be sent to your new physician.

Your medical coverage will continue uninterrupted with your new physician. We encourage you to call the medical facility at (Health Plan Phone Number) if you are in the process of receiving medical treatment for any illness or injury. This will ensure continuity and proper management of your care with your new physician.

You will receive a welcome letter from your new primary care physician's office soon to assist you in this transition (optional).

We certainly hope you decide to continue your (Health Plan Name) coverage. However, you may elect any of the following choices: (a) you may remain with (Health Plan Name); (b) you may disenroll from (Health Plan Name) through (Health Plan Name) or through any Social Security Administration Office or Railroad Retirement Board Office and return to the traditional Medicare program; or, you may enroll in another Medicare-contracting health maintenance organization in the area. (Please be very careful that before signing any document, you fully understand what you are signing.)

We apologize for any inconvenience this change of primary care physician's office may cause you. Rest assured that the same benefits and quality care will be provided to you at your new primary care physician's office.

Thank you for your continued support.

Sincerely,

Plan Representative

CHAPTER VIII

MODEL SUMMARY OF BENEFITS

INTRODUCTION

The model summary provides an abbreviated, side-by-side comparison of Medicare and HMO plan provision of benefits in the areas of: hospital inpatient care; home health care; physician services; other services and supplies; emergency and out-of-area urgently-needed care; immunizations; preventative services; drugs; and vision and hearing services. Instructions for use of the model summary and a list of exclusions from plan coverage are also included.

Please note that as stated in the Instructions and Exclusions sections, any excluded benefits which may be covered by your plan must be included in the Summary of Benefits chart.

MODEL SUMMARY AND COMPARISON OF BENEFITS CHART

BENEFITS	FEE-FOR-SERVICE MEDICARE			HMO MEDICARE		
Hospital Inpatient Care Semiprivate room (private if medically necessary) Meals including special diets Regular nursing services Costs of special care units, such as intensive care or coronary care units Drugs and biologicals Lab Tests X-Rays and other radiology services Necessary surgical and medical supplies Use of appliances, such as wheelchairs while hospitalized Operating and recovery room costs Rehabilitation services, such as physical therapy, occupational therapy, and speech pathology services.	(See below for definition of a benefit period.)	**Medicare Pays**	**You Pay**		**HMO Pays**	**You Pay**
	First 60 days	All but $760	$760			
	61st to 90th day	All but $190 a day	$190 a day			
	91st	All but $380 a day	$380 a day			
	Beyond 150 days	Nothing	All costs			
	Medicare Part A includes an extra 60 lifetime reserve days for hospital stays greater than 90 days.			List days covered and all applicable co-pays.		

A benefit period is a way of measuring your use of services under Medicare Part A. A benefit period begins with the first day of a Medicare covered inpatient hospital stay and ends when you have been out of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row (including the day of discharge).

MODEL SUMMARY AND COMPARISON OF BENEFITS CHART

BENEFITS	FFS MEDICARE	HMO MEDICARE
Hospital Inpatient Care, cont.		
Kidney transplants		
Heart, liver, and lung transplants under certain conditions		
Blood and its administration	You pay for the first 3 pints of unreplaced blood. Medicare pays for all other.	
Skilled Nursing Facility Care		
Semi-private room	You pay nothing for up to 20 days per benefit period following a medically necessary 3-day hospital stay. For days 21 through 100, you pay $95 a day. In accordance with Medicare guidelines.	List days covered, restrictions such as benefit periods, all applicable copays, and whether any prior hospital stay is required.
Meals including special diets		
Regular nursing services		
Physical, occupational, and speech therapy		
Drugs and biologicals		
Medical supplies		
Use of appliances such as wheelchairs while in SNF.		
Hospice	All but limited costs for outpatient drugs and inpatient respite care for as long as the doctor certifies there is a need.	Not provided by HMO. Member elects hospice benefit and receives directly from any Medicare-certified hospice.

Instructions for Use of the Model Summary and Comparison of Benefits

- When the complete Medicare covered benefits are given, it is not necessary to list plan benefits in the EOC; the chart can be referenced in the EOC.

- If an abbreviated version of the model summary is used, the plan must add that enrollees should refer to the EOC for a complete description of benefits.

- The following disclaimers should be prominently displayed, preferably in the cover letter:

    - All Medicare covered benefits are subject to Medicare coverage guide.

    - Neither Medicare nor the plan will pay for services that are not provided or arranged by Health plan providers, except for emergency or urgently needed out-of-area services.

    - (For contractors with a POS benefit feature or Visitors Program: List plan-specific requirements and level of coverage found in your Evidence of Coverage.)

    - (For "Cost" Contractors: After your enrollment is effective, in order for (Health Plan Name) to fully pay for medical services for you, these services (except for emergency and out-of-area urgently-needed services) must be provided or arranged by (Health Plan Name). You may receive services that are not provided or arranged by (Health Plan Name), but you will be responsible for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare Program. You may be liable for any charges not covered by the Medicare Program.) **NOTE TO PLAN:** Be sure to offer adequate explanation of Medicare card use with out-of-plan utilization which is not an emergency or urgently-needed services.

    - Prior authorization.

    - Benefit coverage levels may change annually.

- Any Medicare excluded benefits which may be covered by the plan must be included in the Benefits Chart.

- A summary of the information contained in bullets 6, 7, and 8 in Chapter 3, Sales Packages and Advertising should be included as footnotes, or in some other manner, to inform beneficiaries of the health plan's full Medicare benefit and premium structure.

Exclusions from coverage--See SECTION 7, Services Not Covered.

MODEL SUMMARY AND COMPARISON OF BENEFITS CHART

BENEFITS	FFS MEDICARE		HMO MEDICARE	
Home Health Care Part-time or intermittent skilled nursing care (This can include 8 hours of reasonable and necessary care per day for up to 21 consecutive days - or longer in certain circumstances Physical therapy, speech therapy, and occupational therapy provided in the home Part-time or intermittent services of home health aides Medical social services Durable medical equipment Medical supplies	Paid in full for all covered visits in accordance with Medicare guidelines. When necessary that these services be administered in the home. Medicare Pays 80%; You Pay 20%		List all applicable copays	
Physician Services Office visits including medical and surgical care in a physician's office or certified ambulatory surgical center Consultation, diagnosis and treatment by specialist Inpatient and skilled nursing facility physician and surgical services, including anesthesia Second opinion by another plan physician prior to surgery	**Medicare Pays** % of approved amount (after deductible)	**You Pay** $100 deductible plus 20% of approved amount and limit charges above approved amount	**HMO Pays** List all applicable copays and any additional benefits you offer	**You Pay**

MODEL SUMMARY AND COMPARISON OF BENEFITS CHART

BENEFITS	FFS MEDICARE	HMO MEDICARE
Physician Services, Cont.		
Chiropractic Services Podiatry Services	You pay first $100 per calendar year * plus 20 % of Medicare - approved charges. ** Limited to manual manipulation of the spine to correct subluxation that can be demonstrated by x-ray	
Treatment of injuries and diseases of the feet. (Routine foot care is not covered. See exclusions.)	You pay first $100 per calendar year * plus 20% Medicare - approved charges .**	
Optometric Services Medical eye problems. Routine vision testing and eye exams are not covered. (See exclusions.)	You pay first $100 per calendar year ** plus 20% of Medicare approved charges.**	
Non-Physician Practitioners- Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Nurse Midwife, Clinical Psychologist, Clinical Social Worker, Certified Registered Nurse Anesthetist Dental Services (Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a doctor).	You pay first $100 per calendar year * plus 20% of Medicare - approved charges. **	

* The $100 Part B deductible needs to be met only once per year and applies to all Medicare Part B benefits.

** If your doctor does not accept assignment, then you must pay any unapproved charges up to the Medicare limiting charge, which is 115% of the Medicare approved amount.

MODEL SUMMARY AND COMPARISON OF BENEFITS CHART

BENEFITS	FFS MEDICARE	HMO MEDICARE
Other Services and Supplies Outpatient hospital services	Medicare payment to hospital is based on hospital costs. You pay 20% of whatever the hospital charges are after the $100 Part B deductible is met.	Explain what you cover, including all applicable copays; if coverage is same as Medicare, state that.
Outpatient surgical services Comprehensive outpatient rehabilitation facility services X-rays, including outpatient radiation therapy and portable X-rays used in the home Kidney dialysis Ambulance transportation Durable medical equipment, such as wheel chair Prosthetic devices including corrective lenses needed after a cataract operation, ostomy bags and certain related supplies and breast prostheses (including a surgical brassiere) after a mastectomy Medical supplies, such as dressings, splints and casts Orthotics and prosthetics Therapeutic shoes for those suffering from severe diabetic foot disease	You pay first $100 per calendar year * plus 20% of remaining approved charges.** You may have to pay for all charges above Medicare-approved amounts for some of these services if the supplier does not accept assignment	

* The $100 Part B deductible needs to be met only once per year and applies to all Medicare Part B benefits.

** If your doctor does not accept assignment, then you must pay any unapproved charges up to the Medicare limiting charge, which is 115% of the Medicare approved amount.

MODEL SUMMARY AND COMPARISON OF BENEFITS CHART

BENEFITS	FFS MEDICARE	HMO MEDICARE
Other services and supplies (cont'd)		
Outpatient physical and occupational therapy and speech pathology services	You pay first $100 per calendar year* plus 20% of Medicare - approved charges. There is a maximum of $720 payable for services received directly from an independently practicing, Medicare-approved physical or occupational therapist in his office or in your home.	
Diagnostic tests		
Laboratory services	Medicare pays the full approved fee for laboratory tests.	
Blood - except for the first 3 unreplaced pints used in a year - and its administration	You pay for the first 3 pints of blood used each year unless you have already paid for them as part of your hospital stay. For additional pints, you pay 20% of approved amount after $100 deductible is met.	
Mental health care		
Inpatient hospital services	Coverage is the same as hospital inpatient care with 190-day lifetime limit in a psychiatric hospital.	Explain what you cover, including all applicable copays. If coverage is the same as Medicare, state that.
Outpatient services	You pay 50% of approved charges after $100 deductible is met.*	
Partial hospitalization psychiatric program	You pay first $100 per calendar year plus 20% of remaining approved charges.	

* The $100 Part B deductible needs to be met only once per year and applies to all Medicare Part B benefits.

MODEL SUMMARY AND COMPARISON OF BENEFITS CHART

BENEFITS	FFS MEDICARE	HMO MEDICARE
Immunizations Hepatitis B Vaccine (for those at risk of contracting the disease) Flu shots Pneumonia Vaccine	You pay $100 per calendar Year * and 20% of Medicare approved charges for the Hepatitis B Vaccine.** Medicare pays 100% of the approved amount for flu shots. The Part B deductible and coinsurance do not apply. Medicare pays 100% of the approved amount for the pneumonia vaccine. The Part B deductible and coinsurance do not apply.	List coverage and copays.
Emergency and out-of-area urgently-needed care Emergency services are those that you need immediately because of an injury or sudden illness and the time required to reach the HMO plan's providers would have meant risk of permanent damage to your health. Out-of-area urgently-needed services are those that you need in order to prevent serious deterioration of your health that results from an unforeseen illness or injury if you are temporarily away from the HMO plan's service area and receipt of the health care services cannot be delayed until you return to the service area.	Covered as listed above, depending on whether care is on an inpatient or outpatient basis.	List coverage and copays.

* The $100 Part B deductible needs to be met only once per year and applies to all Medicare Part B benefits.

MODEL SUMMARY AND COMPARISON OF BENEFITS CHART

BENEFITS	FFS MEDICARE	HMO MEDICARE
Vision and Hearing Services		
Routine vision tests and eye exams	Not covered	
Glasses	Medicare will pay for one pair of eyeglasses or contact lenses after cataract surgery with insertion of an intraocular lens, subject to the $100 annual Part B deductible* 20% coinsurance provisions of Part B Medicare.	
Routine hearing exams	Not covered	
Hearing aids	Not covered	
Drugs and Biologicals	Not covered by Medicare except for the following: - immunosuppressive drugs (current time period is 30 months following a Medicare covered organ transplant). - Erythropoietin for dialysis patients - infusion pump and associated IV drugs - antigens - blood clotting factors - osteoporosis drugs - oral anti-cancer drugs You pay first $100 per calendar year * plus 20% of remaining approved charges. You may have to pay charges in excess of Medicare approved amounts if the provider does not accept assignment.	Pharmacy network. Approved plan drug list. **NOTE TO PLAN:** Plan must describe here whether drugs must be from a formulary or not. Generic V. Brand name; copays; monthly, quarterly, annual and lifetime limits; mail order; # of days supply prescriptions.
Preventative Services		
Routine physical examinations	Medicare does not cover routine physical exams.	List coverage and copays.
Mammography screening (every 2 years)	You pay the first $100 per calendar year* plus 20% of Medicare approved charges.**	
Pap smears		

* The $100 Part B deductible needs to be met only once per year and applies to all Medicare Part B benefits.

** If your doctor does not accept assignment, then you must pay any unapproved charges up to the Medicare limiting charge, which is 115% of the Medicare approved amount.

CHAPTER IX

ANNUAL NOTIFICATION GUIDE

INTRODUCTION

This chapter is intended to provide guidance to plans in developing materials related to the annual notification and mid-year benefit changes and to streamline HCFA review of these materials. The first part of this section provides practical advice, a summary of regulatory requirements, and model letters on annual notification. The second part provides a summary of requirements on mid-year benefit changes, and models for the member notification letter and EOC addendum.

Health plans are required to furnish Medicare beneficiaries enrolled in their plan's with a copy of the plan rules at the time of enrollment and at least annually thereafter. If a health plan changes its rules, benefits and/or premiums, Medicare members must be notified by the plan at least 30 days before the effective date of the changes. HCFA has 45 days to review and approve these notices prior to use.

As the beginning of the new contract year approaches, health plans should submit annual notices to HCFA for approval as soon as possible in order to implement the changes on January 1. Use of the model letters and model benefit change comparison chart will expedite review and approval of these documents.

This section contains a summary of regulatory requirements for the annual notification and two model annual notification letters. Also, included in this section is a model benefit change comparison chart that plans can choose to use as a method of describing annual benefit changes to Medicare members.

For approval of annual notifications that include benefit or premium changes, the plan must make sure that the Adjusted Community Rate (ACR) proposal incorporates these changes. Plans wishing to mail such annual notification letters prior to HCFA approval of their ACR are required to provide a disclaimer that the benefits and/or premiums are subject to Federal approval. It should be noted that many states require an advance approval process as well, and may also require a similar disclaimer.

Use of the regulatory guide and model letters provided in this section will expedite the review and approval of your documents. Questions regarding the annual notification process or the model letters provided in the section should be directed to your HCFA Regional Office Liaison.

SUMMARY OF ANNUAL NOTIFICATION REQUIREMENTS

Regulatory Requirements

As stated in 42 CFR 417.436(b), Medicare-contracting plans must "furnish a copy of the rules to each Medicare enrollee at the time of enrollment and at least annually thereafter." To comply with this requirement, plans must send members a copy of the EOC, including the grievance and appeals process, and the member handbook at least once a year.

As stated in 42 CFR 417.436(c), "if an organization changes its rules, it must submit the changes to HCFA in accordance with 417.428(1)(3), and notify its Medicare enrollees of the changes at least 30 days before the effective date of the changes." This notice may be sent with the EOC or separately. (For example, if a plan wishes to send the 30-day notice of changes in benefits on or before December 1 in order for the changes to be effective January 1, but its revised EOC has not yet been published, it may send the EOC under separate cover after it has been printed.)

NOTE TO PLAN: If there are no changes in a health plan's Medicare product for the coming year (i.e., neither changes made by the plan nor any new benefits now covered by Medicare), you are not required to send an annual notice of changes. Health plans are only required to send the EOC and any documentation that addresses the following topics: limitations on coverage, procedures for changing providers, and the grievance and appeals process.

Required Information for Annual Notices

The annual notice should contain the following information:

1. Explanation of Contract Renewal. Explain that Medicare has reviewed and approved the changes indicated in the letter. If a health plan's ACR has not been approved by HCFA, the notice should clearly state that the changes are subject to approval by HCFA.

2. Effective Date. The notice should clearly state the effective date of the changes. Remember, the member is entitled by regulation to receive at least 30-days prior notice of any changes in benefits, premiums, or copayments.

3. Description of Changes. Any and all changes to benefits, premiums, copayments and other costs to the member, and rules should be clearly and completely described in the notice. Comparative charts may be helpful (but are not required) to explain benefit changes. A model chart follows which may serve as an example.

4. EOC. Explain that the revised EOC or similar document is enclosed or will be sent under separate cover as soon as it is printed. If none of the information contained in the EOC has changed, Health plans may send out the most recent version.

5. New Medicare Covered Benefits. If Medicare covers new benefits, list and clearly explain these in the notice.

6. Contact for More Information. List the department and phone number where members can receive additional information on benefit changes.

7. Appeals and Grievances. See Section 11 of this Guide.

8. Explanation of Physician Incentive Plan Regulation.

The following statement must be included in a health plan's annual notice, revised pre-enrollment materials (Member Handbook), and in revised EOC:

"Effective January 1, 1997, Medicare-contracting health plans such as (Health Plan Name) must provide you the following information:

- Whether we use a physician incentive plan (PIP) that affects the use of referral services (provide the information).
- The type of incentive arrangement (provide the information).
- Whether stop-loss protection is provided (provide the information).
- If a member survey is required because of our PIP, we will conduct a survey in (year). A summary of the results will be available in (year) (provide the information).

You are entitled to ask if we have special financial arrangements with our physicians that can affect the use of referrals and other services that you might need. To get this information, call our Member Services Department at (Health Plan Phone Number) and request information about our physician payment arrangements. We will send this information to you within 30 days."

NOTE TO PLAN: See page 119 for Model Beneficiary PIP Information request response letter. This letter should be used when responding to beneficiary requests for Information on (Health plan Name's) PIP Program. See page 124 for mid-year benefit change notification information.

MODEL BENEFICIARY PIP INFORMATION REQUEST RESPONSE LETTER

(Suggested for use when responding to beneficiary requests for health plan's PIP Information. If your health plan does not have a PIP Program, a letter to the beneficiary stating that fact is required.)

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

You have asked for information regarding (Health Plan Name)'s Physician Incentive Plan Program. The Health Care Financing Administration (HCFA) requires us to give our members important information about the contractual relationships we have with our physicians. These contractual relationships include the way we pay physicians and could affect your use of referrals and other services that you might need. To understand these arrangements, we need to define several words. **NOTE TO PLAN:** You do not need to include any terms below which are not used in the incentive plans of your physicians.

1. Discounted fee-for-service. Physicians are paid a pre-determined amount for each service they provide. Both the physicians and the health plan agree on this amount each year. This amount may be different than the amount the physician usually receives from other payers.

2. Capitation. Physicians are paid a fixed amount of money each month to provide specific services to the members they see. This capitation payment may be divided into separate amounts for the services they provide directly to their patients, services provided by referral physicians, and for hospital and other types of services.

3. Bonus. At the beginning of each year, both physicians and the health plan agree on a goal for the amount of services or cost of services patients will use. At the end of the year, the health plan pays physicians an extra amount of money if patient care cost less money or patients used fewer services than the budgeted goal agreed to at the beginning of the year.

4. Withhold. At the beginning of each year, both physicians and the health plan agree on a goal for the amount of services or the cost of services their patients will use. However, the health plan keeps a portion of this payment. At the end of the year, if physicians overspend or exceed this budgeted goal, the health plan keeps the amount of money it withheld. If physicians underspend or use fewer services than budgeted, the health plan gives the withheld amount of money back to the physicians.

5. Stop-loss insurance: Special insurance for physicians which protects them from very large financial losses. HCFA requires physicians to have this insurance if more than 25 percent of their pay could be lost if they refer patients for more than the health plan budgeted goal. **NOTE TO PLAN:** You should note here or elsewhere in the notice whether or not stop-loss protection is provided to your physicians and physician groups if required by the regulation.

We have several different types of contractual arrangements with our physicians. **NOTE TO PLAN:** The following are some examples of arrangements frequently used in the contracts or subcontracts of health plans. You should provide general descriptions on a representative sample of arrangements used in your contracts and subcontracts. This set of descriptions can then be used for all beneficiaries requesting physician incentive plan information. You are not expected to provide specific information about the incentives faced by a given beneficiary's physician.

Arrangement A: We pay our physicians salary. At the end of the year, physicians can get a bonus if their patients used fewer referral services than the budgeted goal.

Arrangement B: We pay our physicians a capitation for primary care. We withhold separate amounts for referral and for hospital services. At the end of the year, physicians can get these amounts paid to them if their patients used fewer referral services and spent fewer days in the hospital than the budgeted goals.

Arrangement C: We pay our physicians discounted fee-for-service. We withhold a separate amount for referral services. At the end of the year, physicians can get these amounts paid to them if their patients used fewer referral services and spent less days in the hospital than the budgeted goals. We also pay physicians a bonus if their patients spent fewer days in the hospital than the budgeted goals.

HCFA also requires us to survey our current and previously enrolled members to determine if they got the care they needed and if they were satisfied with the quality of services they received. You can request information about the results of this survey by contacting our Member Services department at (Health Plan Phone Number). (Health Plan Name) is not required to conduct the survey before (Date). Therefore, this information will be sent to you by (Date). **NOTE TO PLAN:** For health plans conducting their surveys, we expect that health plans will analyze and summarize survey results for beneficiaries within 4 months after the survey is conducted. HCFA will provide Health plans with a copy of their organization's summary results from the Medicare Consumer Assessment for Health Plans Survey on a similar time line.

MODEL ANNUAL NOTIFICATION LETTER A

(Suggested for use when the EOC and other member literature is being sent along with the 30-day notice of annual benefit changes.)

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

Effective (Date), your monthly premium that you pay to (Health Plan Name) will be (Increased/Decreased) from $_____ to $_____. The following benefits* provided by (Health Plan or Product Name) will (Also Change/Remain the Same) on (Effective Date):

(Clearly describe all benefit changes, including changes in copayments, annual cap, drug coverage, other limitations, and any new benefits offered by the plan for this year.)

In addition, effective (Date), Medicare and (Health Plan or Product Name) now cover the following new benefits:

(Clearly describe all new Medicare-covered or health plan benefits.)

All of the (Changes and/or New Benefits, if applicable) are fully described in the revised Evidence of Coverage document and Summary of Benefits chart, which are enclosed. There are no other changes in coverage or copayments.

If you have questions about these changes and/or new benefits, please call the Member Services Department, Monday through Friday, (Hours of Operation) at (Health Plan Phone Number).

We look forward to serving you now and in the future.

Sincerely,

Plan Representative

Enclosure

* Subject to Federal (and State) approval. (Only necessary if federal and/or state approval not yet obtained.)

(Include language which identifies changes in a health plan's appeals process, grievance process, and PRO review process including but not limited to changes in contact and phone numbers.)

MODEL ANNUAL NOTIFICATION LETTER B

(Suggested for use when the new EOC and other member literature will be sent under separate cover after publication.)

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

Effective (Date), the monthly premium that you pay to (Health Plan Name) will be (Increased/Decreased) from $_____ to $_____ . The benefits provided by (Health Plan or Product Name) will remain the same as in (Year) except for the following changes*:

(Clearly describe all benefit changes, including changes in copayments, annual cap, drug coverage, other limitations, and any new benefits offered by the plan for this year.)

In addition, effective (Date), Medicare and (Health Plan or Product Name) now cover the following new benefits:

(Clearly describe all new Medicare-covered benefits or health plan benefits)

All of the (Changes and/or New Benefits, if applicable) are fully described in the revised Evidence of Coverage document and Summary of Benefits chart which you will be receiving. There are no other changes in coverage or copayments.

If you have questions about these changes and/or new benefits, please call the Member Services Department, Monday through Friday, (Hours of Operation) at (Health Plan Phone Number).

We look forward to serving you now and in the future.

Sincerely,

Plan Representative

*Subject to Federal (and State) approval. (Only necessary if federal and/or state approval not yet obtained.)

MODEL BENEFIT CHANGE COMPARISON CHART

(Health Plan or Product Name)
(Effective Date)

Following are the benefit changes for (Year):

Benefit Changes	In (Old Year) * you paid	In (New Year) you will pay
Changes: Routine office visits at an affiliated primary care physician's office	$5 office visit copayment per visit	$10 office visit copayment per visit
New Benefits: Preventive dental exam every 6 months	Not covered	$5 copayment per visit

*Subject to Federal (and State) approval. (Only necessary if Federal and/or State approval not yet obtained.)

MID-YEAR BENEFIT CHANGE NOTIFICATION

For plans that opt to offer mid-year benefit changes (e.g., increased benefits, lower premiums, or lower cost-sharing amounts), a 30-day advance notice is required.

In addition, the plan must update the EOC or other contractual agreement to reflect the new benefits. This requirement can be met either by issuing a revised EOC or sending an amendment or addendum to the EOC.

Following are models for both the member notification letter and the EOC addendum. Use of these model letters will expedite HCFA's review and approval of these documents.

The 30-day advance notification requirement associated with any change in member rules does not apply to all situations. However, where a mid-year benefit change is limited to increased benefits with no cost-sharing, lower premiums, or lower other cost-sharing amounts, this 30-day advance requirement may be waived. The 30-day advance notification cannot be waived when the mid-year benefit change has benefit cost-sharing in the form of copayment, deductible, or coinsurance. Please contact your HCFA regional office liaison.

NOTE TO PLAN: For changes occurring in the middle of the contract year that were approved in the original ACR proposal filed before the beginning of the contract year, notification to enrollees would have been included in the annual notification letter. Therefore, this type of change would not require a notification. A reminder notice sent prior to implementation of this type of benefit change may decrease beneficiary confusion but is not required.

MODEL MID-YEAR BENEFIT CHANGE LETTER

Date

Name
Address

Medicare Number
Member Number

Dear (Member Name):

(Health Plan Name) is pleased to offer (a Higher Level of Benefits/a New Benefit/a Lower Premium/ etc.). Beginning (Date), the following changes apply and will be effective for the remainder of (Year):

(Fully describe benefit/premium change)

Enclosed is an addition to your Evidence of Coverage (EOC) document, which takes the place of the (Changed) benefits described in the current EOC. Please keep this additional information with your EOC at all times for future reference.

If you have questions about these changes and/or new benefits, please call the Member Services Department, Monday through Friday (Hours of Operation) at (Health Plan Phone Number).

Sincerely,

Plan Representative

Enclosure

ADDITION TO (HEALTH PLAN NAME)
EOC BENEFIT CHANGE

The benefit changes described in this addition take the place of (or are in addition to as applicable) the benefits described on page (Page Number) in your EOC document.

Effective (Date), (Fully describe all benefit changes, benefit additions, and/or premium reductions. All limitations and conditions must be fully explained.)

CHAPTER X

USE AND FILE

IMPLEMENTATION OF A USE AND FILE SYSTEM

The Use and File System

This system was designed to streamline the marketing materials and activities review process. Under this process, plans that can prove to HCFA that they can continually meet a particular standard of performance will be able to publish and distribute certain marketing materials without prior HCFA approval. The Use and File system has several advantages -- it is a time-saver for both HCFA and health plans, and plans can schedule their advertising without waiting for HCFA approval.

This section outlines the criteria for initial and ongoing eligibility for the Use and File system, HCFA tracking of Use and File status, and recommendations for obtaining Use and File status.

Use and File Definitions

Eligible Material: All material used to market the health plan to non-members. This would includes all ads (print as well as media), and certain other material such as sales scripts, sales presentation flyers, and direct mail pieces.

Materials that are **not** eligible for the Use and File system include those materials that describe membership rules and benefits, such as: EOC-Member Handbook; Summary of Benefits; and Member Notices (such as Annual Notice, Enrollment/Disenrollment-related materials and notices, provider termination notices, claims denial notices etc.).

OKAY: All material that is correct as written, or, if it needs modification, the changes requested are minimal and/or could have been approved without revision. In other words, there are no phrases or terms used that are listed in the Can Use/Can't Use/Must Use Guide that fall under the category of "Can't Use." Likewise, there are no phrases or terms listed under "Must Use" for the particular marketing material type that are omitted from the material. In addition, materials generally must not appear misleading and clearly represent the plan's product as well as the Medicare program.

NOT OKAY: All material that does not meet the definition of "OKAY." This would include material that is misleading, incorrect, or is contrary to what is specifically delineated in this Guide.

Eligibility for the Use and File System

To become eligible for the Use and File System, a plan must submit marketing material that meets the following criteria:

1. 95 percent of materials submitted during the preceding quarter were approved without major revisions requested by HCFA ("OKAY" per Use and File criteria).

2. The plan needs to demonstrate that it has a solid understanding of HCFA marketing criteria in a number of marketing pieces.

3. The HCFA Regional Office Managed Care Specialist assigned to the plan must give approval.

4. The plan must have been in the program for at least 18 months.

NOTE TO PLAN: Health plans converting from cost to risk contracts with a total of 18 months experience, and an acceptable marketing history can qualify for Use and File.

Criteria for Continuation of Use and File Status

1. The health plan must provide HCFA with copies of all printed materials within 10 days of their use. Health plans must specify date of initial distribution or publication when filing materials with HCFA.

2. The health plan continues to submit materials that are not eligible for publication prior to HCFA review under the Use and File system (for clarification, see "Eligible Material" section).

3. Health plans may lose approval to use the Use and File procedure if they use misleading or incomplete materials discovered through complaints or spot checks or they fail to file materials within 10 days after distribution or publication.

4. Health plans that would like to use this procedure must agree to retract and revise materials which are found to be misleading or incomplete.

5. Health plans that have Use and File privileges may still submit for prior approval any materials ("Eligible Materials") on which they would like guidance from HCFA. This will prevent plans from losing Use and File privileges for using misleading or incomplete materials, as explained in Item 3 above.

Recommendations for Obtaining Use and File Status

1. Health plans should share marketing guide with the plan staff as well as plan-contracted advertising agency staff who are involved in the development of marketing materials related to the Medicare product. It is also a good idea to have a central contact person who is familiar with the Guide give materials a final review before sending them on to HCFA to ensure that Use and File criteria are met.

2. Health plans should carefully review marketing materials that are deemed by HCFA not to meet Use and File criteria to determine trends. Sometimes there are recurring patterns of mistakes. Also, plans should review comments by HCFA reviewers on materials.

3. One place where mistakes usually occur is the disclaimer language. It may be a good idea to discuss with HCFA and spell out, in writing, the specific disclaimer language that will be part of particular types of materials -- radio/television ads, direct mail pieces, news ads, etc. That way, the plan can refer to their agreement with HCFA when preparing materials for submission and HCFA can refer to the agreement when reviewing the plan's marketing materials.

Operational Considerations--Questions and Answers

1. Q What if a health plan has Use and File status at the regional level and the national level does not, or vice versa (multi-site, chain organizations)?

A Multi-site companies can maintain Use and File status for individual contracting entities as well as for all contracted entities. The Use and File status of a single company and any multi-site entities are independent of each other. Individual companies can maintain this status when multi-site entities do not. In addition, a multi-site company can have Use and File status when individual companies do not.

Use and File status for individual companies is maintained by the region which is responsible for monitoring the company's contract. Multi-site Use and File status is maintained by one region which is part of the multi-state monitoring process (the lead region concept).

2. **Q** Can you quantify what the Guide means when it says..... "the health plan needs to demonstrate that it has a solid understanding of HCFA marketing criteria in a number of marketing pieces"?

A The health plan must have submitted a minimum of 10 marketing pieces in a quarter that are "Eligible Material" for HCFA review.

3. **Q** For quarterly accounting purposes, is a piece of marketing material submitted for Use and File status determination counted for the quarter in which the document is submitted to HCFA or in the quarter when HCFA sends the evaluation response letter to the plan?

A It is counted according to the date it is submitted to HCFA for review. The date on the submission document is the determining date.

4. **Q** Should the failure to submit required supporting documentation (e.g., survey results, newspaper articles, etc.) for a marketing piece, along with the initial request for review of the primary document, result in a "Not Okay" determination?

   A Failure to submit support documentation should not result in a "Not Okay" finding. Instead, the date of submission should be changed to the date when all materials are received and are ready for review. This means if a health plan fails to submit a survey that belongs to a marketing piece, HCFA should inform the health plan about the omission of the additional material and, when it arrives, consider this date the submission date for the Use and File period.

5. **Q** Sometimes health plans re-submit a piece that was originally rejected by HCFA. If HCFA determines that the piece meets approval on the basis of Use and File criteria the second time around, will that piece be counted in the tally for gaining approval for use of the Use and File procedure?

   A No. HCFA will not count materials for the tally to meet Use and File status if the health plan materials conform only after HCFA review and comment. Such a policy would result in health plans with little understanding and inadequate knowledge of HCFA marketing principles to obtain Use and File status. Under such a policy, a health plan could submit substandard materials 10 times and still qualify for Use and File status. This would clearly undercut the "marketing quality" intent that HCFA associates with Use and File status.